

**MUST YOU
BE DRAFTED?**

**DO YOU
KNOW YOUR RIGHTS?**



A Doctor's Guide to the



**Every legal medical exemption.
With a complete description of symptoms
that may indicate a disability.
Illustrated with line drawings**

FRANK FORSTER, M.D.

**Foreword by Bishop C. Edward Crowther
Famed worker for the Peace Movement**

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FRANK FORSTER, M.D.

spent three years as a doctor with the British Army of Occupation in Germany, following World War II. Now a resident of Southern California, he considers himself a patriot, and would immediately volunteer his services in the event that the United States was attacked by a foreign power. However, he feels that the present conflict in Southeast Asia is both immoral and illegal.

BISHOP C. EDWARD CROWTHER

was formerly Episcopal Bishop of Kimberly and Kuruman, Union of South Africa. At present he is serving as liaison for church and educational institutions for The Alliance for Labor Action, of Detroit.

I am indebted to Hallock Hoffman of Santa Barbara for encouragement and technical advice. Without the selfless interest of my friend, Eustace Cockrell, the book would never even have been started. My wife contributed coffee, unflagging inspiration, and endless patience.

For my two sons; and young men everywhere.

A Doctor's Guide to the

DRAFT

FRANK FORSTER, M.D.

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A DOCTOR'S GUIDE TO THE DRAFT

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FOREWORD

Whatever might be the level of moral concern about war in general and the Viet Nam war in particular, the outcome of the bizarre draft lottery affects the life of nearly every youthful male in the United States.

Of course, not everyone views his winning number with dismay. To some boys military service comes as a welcome relief from boredom, or from a life turned sour by one or more of the many emotional and physical forms of deprivation rampant in our society. Others see service in the armed forces in more or less patriotic terms which make it at most a privilege, at least tolerable. For the majority of young men who do accept induction, military service represents an inevitable and unavoidable chore, more in the nature of a stripe than a star.

It is surprising how many boys are unaware of the provisions made by law for draft deferment. Such provisions should be seen as legal rights to be exercised, if applicable, just as surely as the right to vote. There will be a few young men who could not care less whether they go to Las Vegas or to Viet Nam—it's all a game anyway. But there are others, many thousands of others, who care passionately about their relationship to the draft. On the campuses of our high schools, colleges and universities,

whether for reasons of conscience or enlightened self-interest, determination to avoid military service is accepted as a valid response. On the other hand, many parents who respond to an entirely different kind of societal expectancy find the attitude of youth to their country very difficult to understand. The parent who resents his son's disregard for the effect of his conscientious objection to war on friends, neighbors and business associates would do well to ponder what such priorities say to his son.

The old cold war, of which Viet Nam seems like a warmed up left over, has been replaced in the eyes of our young with more contemporary and relevant crises. Kent State and Jackson have replaced the Berlin Wall as the fearsome symbols of a new and infinitely more immediate conflict.

It seems increasingly that our society is drifting at home almost inadvertently into another undeclared, unwinnable, but very real war, this time with our youth. Between the need of the power structure to survive and the need of a disenchanted youth to find some viable options, a cultural and life-style Grand Canyon has emerged. The most superficial guided tour reveals its obvious features. The defense of real estate and inanimate private possessions seems to justify the ultimate violence to people. In Isla Vista the burning of The Bank of America spoke eloquently of what symbols on both sides can mean and demand in blood.

Long hair and unorthodox dress produce a counter-reaction by a society which is easily threatened by such symbolism. We ascribe and commit to the devil our fears, and deal accordingly, with those who generate them, often in the name of God. In terms of social and often legal consequences, the new blacks in our racist society are our long haired and bearded youth. A new community of the discriminated-against is being built and white youth stands in Square One of the tragic game in which the blacks, Indians and chicanos are way ahead.

Evidence of the undeclared war being waged against

nonconformist youth is seen in some of the options we present to them. In the foreground is the power of law enforcement, seen today in a role far removed from that of the peace officer. The specter of protection against our protectors haunts many of us who have witnessed what happens when the guardians of the law are unleashed in defense of order. A military mentality shows up with ominous regularity whenever the threat to the status quo possesses the symbols that release the trigger mechanism of our fears. As the major said of Hue, so many say of the contemporary counter-culture, "In order to save it, we must destroy it."

Such attitudes backed by the power to enforce them show up time and again in the extreme options offered to youth where the war is concerned. They can either go into the army or go to jail. To train as a killer or to be withdrawn from society are unacceptable options to many young men. In between these options there is a shadowy no-man's-land of possible escape.

There is voluntary exile, of course, usually to Canada, which is the choice made by considerably more people than is generally realized in the United States. And, oh yes, there is always the 1-Y classification—medical deferment—but who thinks about that until the last minute? Anyway, medical deferment is at best a consolation prize for the diseased. It has become a last ditch method for avoiding military service and in our body-oriented culture, it is often resisted! But this need be so no longer. The importance of this book is the uncovering of a most obvious, easily accessible and legitimate door to freedom from military service. The point is that ignorance of ways to cash in what might be an adequate credit in our long-neglected physical or emotional bank account need no longer apply. A new option is hereby presented by Dr. Forster. Those approaching draft age would do well to consider it.

The opportunity, enlarged by the Supreme Court, to apply for C.O. status is used increasingly. Draft boards throughout the country are jammed with cases. The

growth of draft counselling centers, sponsored by churches, schools and many other agencies, guarantees to an ever increasing number of young men highly skilled and dedicated advice on provisions made by law for deferment or exemption classification.

The readers of this book should make themselves familiar with the draft counselling service most readily available. It is terribly important to prepare to meet the draft well in advance. So often things are left until too late. What applies to medicine applies to the draft—prevention is better than cure! Many sixteen and seventeen year olds are worried about the draft, and wisely so. High school is the proper place to begin planning for a valid and legitimate response to the draft. It is common sense to know what legal options are available.

It is no more immoral or unpatriotic to claim an available exemption from military service than it is to claim legitimate exemptions when filling out a tax return. Skilled advice is an asset, so it should be sought as soon as possible. When there is a choice of possible deferment classifications, for instance between 1-O or C.O. status, and 1-Y medical deferment, it is wise to know what are the consequences of the options.

C.O. status has its pitfalls. There are some extremely unpleasant consequences to success. Frequently cited is the attitude of local draft board members themselves. They tend to regard the C.O. as a cop-out who deserves some sort of punishment for two years. The Bible might proclaim, "Blessed are the peacemakers," but that applies to the Kingdom of Heaven, not, it appears, to most draft boards. To live by the sovereign demands of individual conscience may be all right as a rationale of profitmaking and private enterprise, but not when it comes to fighting for your country, right or wrong.

Whatever is claimed to be the intention, the practical effect of C.O. status being granted is to simulate as nearly as possible the effect of induction into the army. Specifically, the C.O. must change his type of work, he must move away from his local area; his level of pay must be

similar to what an army private makes. For two years, the conscientious objector must work in a job approved by his draft board, which tends to be very restrictive in what is approved. Any job, for instance, which can be filled from the local labor market is out, and so it seems is anything involving status, salary, or the need for creative thought. To find a job meeting the requirements of the local board takes time, so those applying for 1-O classification should have definite civilian work suggestions to offer. To refuse civilian work approved by the draft board after due process is to invite the same penalty as for refusing induction.

There is more, much more to being a C.O. than merely to escape military service. There is the very real and valid moral principle that objection to war itself must be made whatever the consequences. For this reason, many fine young men have chosen jail rather than compromise their principles. For this there should be medals for peace offered by a society grateful that its conscience is guarded by so many of its young. There will be those who, regardless of any possible medical reason for draft deferment, will wish to register their dissent from what the very existence of the draft represents. There will be many, however, who while continuing to work for peace or their own career will gratefully exercise any available right to medical exemption.

This book meets a real need. Ignorance of medical terminology, unfamiliarity with procedures long obscured by professional medical mystique, and the usual failure to look far enough ahead, all have contributed to much needless trauma, personal sacrifice and expense.

In my own draft counselling, I shall advise a thorough investigation of the possibility of 1-Y classification. So many other bridges need never be crossed again. This book can be a life saver—which is what, from a medical doctor, we have every right to expect.

Rt. Rev. C. Edward Crowther
Episcopal Bishop

"Today all across our country we face a crisis of confidence. Nowhere is it more acute than among our young people. They recognize the draft as an infringement on their liberty—which it is. To them, it represents a government insensitive to their rights—a government callous to their status as free men. They ask for justice—and they deserve it.

So I say, it's time we looked to our consciences. Let's show our commitment to freedom by preparing to assure our young people theirs."

Richard M. Nixon: October 17, 1968.

Preface

I have many motivations for writing this book, but for the sake of conciseness, I will deal briefly with only two.

First, as a doctor, I suppose I have a greater interest in the preservation of human life than in its destruction, especially when it concerns healthy young men who by all rights should have long lives ahead of them. The slaughter of these youths in Vietnam and elsewhere is extremely tragic and saddens me. What is worse, I can find no logical justification for it. This is a personal, humanitarian view of my own.

Second—and here I must admit to a certain ideological bias—I consider that the war these young men are being sent to fight, and in which they are being maimed and killed in large numbers, is evil, stupid and totally unnecessary. But more able tongues and pens than mine have elaborated on this issue, and will, I hope, continue to do so. I shall leave the philosophical arguments to them.

As to a justification for what I write, I hasten to state that I am *not* a pacifist and that, should the security of the United States be threatened, I would be among the first to enlist. Indeed, I spent three years as a medical officer in the British Army in Germany, and I was not a draftee.

In my opinion, this endeavor to assist young men in their efforts to prevent endangering their lives in a war which is unpopular with the vast majority is no more treasonable, libelous nor unpatriotic than books written by those who, by every legal means—and some not so legal—would assist us to avoid paying taxes. Nor can the people who instruct us in how to circumvent various traffic, and other, laws of the land be labeled traitors. A point I must make here is that if through my efforts even one young man were to be excused from military service because of a physical defect which might not otherwise have been discovered until he had already undergone his training period, an appreciable amount of taxpayers' money will be saved.

That young men, who because of their age aren't allowed to vote—and therefore have no say in shaping the laws of the land, nor in controlling the destiny of their country—should at the same time be forced to take up arms in support of the present fracas, is in my opinion, grossly unjust and indefensible.

Finally, to my certain knowledge—supportable by statistics and examples throughout the text—youths have been inducted into the armed services of this country with physical defects. Because of their own reticence, and/or lack of knowledge, and/or the inefficiency of the induction medical examination, these defects were not discovered until the youths were already in the service, sometimes even on combat duty in Vietnam. They have had to be given medical discharges.

This book is not meant to be a medical textbook; indeed, that would defeat its purpose. Rather is it directed to the intelligent layman. I have therefore attempted to compromise between medical terminology and everyday language in an attempt to interpret for the reader the syndromes and diseases to which we doctors are inclined to give high-faluting names, and which we shroud in mystery. It cannot supplant a frank discussion with a sympathetic doctor of your choice, nor is it meant to do so.

This is perhaps a good point at which to interject an observation regarding non-medical loopholes for avoiding the draft. I refer to conscientious objection, legal bases, political and occupational exemptions. I have little knowledge of such things but refer the reader to a recent publication, "Guide to the Draft," by Arlo Tatum and Joseph S. Tuchinsky (Beacon Press 1969). Of course, for this purpose, a sympathetic lawyer would be invaluable.

The main body of this book is based on an evaluation and interpretation of the government publication *Army Regulations* (AR 40-501), *Medical Service, Standards of Medical Fitness* (November, 1969). As far as we are concerned, the applicable part is Chapter Two: "Medical Enlistment Standards for Appointment, Enlistment and Induction" (Short Title: "Procurement Medical Fitness Standards"). This deals with the various medical and surgical diseases which render a subject unfit for induction (or enlistment!) under ordinary peacetime conditions. Appendix C gives a reprint of this chapter. The complete publication, covering the medical standards required under any condition, including mobilization, can be obtained by sending \$1.75 to US Army Publications Center, 2800 Eastern Blvd., Baltimore, Md., 21220.)

Without better than average medical knowledge, the publication will be of little use. I feel I can be of assistance as a sort of liaison in explaining the medical terminology. I have placed emphasis on certain conditions in the various bodily systems, which I know from experience are more likely than others to render the draftee uninductible. For his further help, I have attempted to illustrate some of these ailments with simple diagrams.

Having been trained mainly in internal medicine, there will inevitably be certain minor inaccuracies in my description of, and dissertation on, certain conditions. Specialists in those fields may take issue. Nevertheless, as I said before, this isn't meant to be a medical textbook, and the descriptions will be sufficiently accurate for our purposes.

It will be my contention throughout the book that a person's body is his own personal property, and that, as such, he is entitled to use (or abuse) it to any extent he wishes, and for any purpose, and at any time he chooses, provided that such actions or omissions on his part do not interfere with the rights of others and does not break any laws. For instance, a person allergic to poison oak cannot be denied the right of walking in the woods where the plant abounds. Or, a diabetic may choose not to take insulin, and thereby endanger his health and maybe even his life, but he does not commit a crime or break the law by doing so. Such illustrations are perhaps farfetched and fanciful, but they are nevertheless valid.

PART I

The Draft Physical

The medical examination for induction varies from center to center throughout the country. Whereas in some areas you are submitted to a thorough and elaborate physical checkup, these areas are unfortunately few and far between. The whole induction procedure is usually conducted in a conveyor belt-like style, and the examination is of such a cursory and superficial nature that it can truly be said that you are "in" if you are still breathing and have two arms and legs.

On the other hand, you may be lucky enough to be examined by doctors who are in sympathy with your dilemma and who will do their best to find some condition that renders you ineligible. However, such men are in the minority. You are much more likely to be confronted by career medical officers who are not just unsympathetic, but downright hostile.

From interviews conducted with scores of young men who have been examined for the draft, the following account was compiled as presenting a fairly typical day at the induction center.

You present yourself at the center at 7 A.M. and are

ushered into a waiting-room with dozens of other young men, where you are instructed not to smoke, gamble or drink alcoholic beverages.

Some time later you are taken to another section of the building, where you undress to your underpants, have your chest X-rayed, and produce a urine specimen.

Next comes a written test of your literacy and proficiency in the English language. Some arithmetical problems are also presented, but if you answer the questions honestly, and make any attempt at all at the sums, you would need to be a congenital idiot (or completely ignorant of English) not to pass with flying colors. This part takes about an hour.

You are then presented with a medical questionnaire, which you are instructed to complete by placing an X opposite any of the listed conditions you have had, or think you have had.

You are given another form which asks if you have ever been a member of any organization, sect, institution, or other group of people considered to be subversive or undesirable. Before filling in this one, you are given instructions by a sergeant or other non-commissioned officer, that you *must* answer each question specifically with a "yes" or "no." Among the societies listed are the Communist Party, the Ku Klux Klan, the Southern Negro Youth Council and many others, the existence of which you are most likely unaware.

Form-filling completed, you then begin the medical examination. A line is formed, and one by one you shuffle past a sergeant seated at a desk and present him with your completed forms. If he bothers to look up at all, it is merely to shoot a cursory glance at you before stamping "normal" opposite each of the twenty-five boxes you have filled in.

At last you meet a doctor who checks your heart, lungs and blood pressure, and prods your abdomen. This part of the examination may be slipshod in the extreme or quite efficiently and conscientiously performed, depending on the eagerness or ennui of the examiner.

The next doctor is a sort of arbitrator who listens to any reasons you may have for considering yourself unfit for military service. Again, the reception and examination you get from this MD will vary widely.

This seems to be a determining point which separates the examinees into two categories: those who have letters from their own doctors, and those who have not. This at least would seem to be the case judging by the attitude of the doctor. Should you be unlucky enough *not* to possess such a letter, you may find it extremely difficult to convince your evaluator.

Next you have a hearing test. Then you see the final doctor. The oracle. The ultimate judge, it seems, who decides your fate. He appraises all the evidence, and then stamps your classification on your card, and informs you of it.

You are then advised that if you think you have not been fairly treated and adequately examined, or if you have any "beefs," you should go to a stated location in the building for a further interview. By now, however, it is well into the afternoon. Quite likely you are starving and have had just about as much as you can take of forms and sergeants and doctors. There are few who bother to dally in further protest.

And that's that. You are either relieved at having failed, or if your classification happens to be IA, you return home to await the inevitable call to the colors—unless of course, you decide to appeal. But more on that later.

All is not gloomy, however. The "fail" rate varies from about twenty percent in the "worst" centers to as high as fifty percent in others. Such a discrepancy is due to a great variety of factors, some of which have been hinted at already.

Do's and Don'ts before the Draft Physical

After you have had your induction physical and have been medically classified, it is still not too late to do

something about having your classification changed. However, such a step may prove to be extremely difficult and complicated. You will already have committed yourself to the answers you have given on the medical questionnaire, which by now will have become a matter of official record and thus not easily altered. You are entitled to appeal your initial classification, however. (See Appendix B on how to go about this.)

It is thus advisable—even imperative—that action be taken *before* you are called for your induction physical. Sometimes it may be wise to do something about the problem many months or even years before the anticipated event. Anyway, *before*. It may thus be possible to have yourself classified as medically unfit for induction by correspondence alone, and completely obviate the need to undergo a draft physical.

Choosing a doctor. This is probably the most important step you will have to take, and your choice may well spell the difference between induction and rejection.

Unfortunately, the majority of doctors in this country are anything but sympathetically disposed towards those who would escape the draft by any means, even for medically legitimate reasons.

This observation is not meant to castigate doctors, nor to deny them their right to their own opinions and sympathies. It is merely a statement of fact. The AMA, to which doctors must belong if they want to preserve their hospital privileges, is well known to be one of the most right-wing organizations, with one of the most powerful lobbies in Washington.

As a general rule—but by no means exclusively so—you will find that younger doctors, and doctors from minority groups—Mexican-Americans, Negroes and Orientals (and one or two Irish!)—are more likely to be sympathetically disposed to your cause than are others. Like so many generalizations however, such an observation is open to a multiplicity of exceptions. The Draft Counseling Service is best qualified to advise you on the local

medical fraternity. (See Appendix A for the address of the nearest one to your home.)

A word about your family doctor. Although he may have brought you and your siblings into the world and may have ministered to the medical needs of you and your family from time immemorial, he may be unsympathetic to the idea of helping you avoid the draft. This draft business is a particularly touchy situation to a lot of people. Absolutely nothing can be taken for granted.

Go to the Draft Counseling Service and see whatever doctor they suggest. When you go to make your appointment, it may be good to acquaint his secretary with the nature of your visit, i.e., a pre-draft physical examination. This way you may determine the attitude of the doctor to this question. Medical secretaries very often reflect the attitudes of their employer. It would also be good to have with you a copy of the army medical pamphlet. If the doctor is used to such matters, he should have one himself, but don't be afraid to present him with the pamphlet. Unless he happens to be the type you would not have chosen in the first place, he will not be offended by this, but will be glad of its help towards advising you.

The doctor will then examine you and tell you of any defects he finds which may render you unfit for service. It will be up to him to send you for any tests that he considers necessary to substantiate your case. If he refers you to a specialist, he should refer you to one that's likely to submit a "favorable" report on your ailment.

Don't pick a specialist yourself. You don't know how he thinks. Even though he may give you "a letter for the draft," you as a layman cannot interpret it. It may be couched in such ambiguous terms that he will "damn you with faint praise," and ruin rather than help your chances. I have seen a few such letters. Let your doctor interpret such documents.

Don't be a fool and "go it on your own." I have encountered smart-alecks who presented themselves for the

draft physical having previously ingested amphetamine or related tablets ("bennies", "speed", "mets") in order to cause a temporary rise in blood pressure or pulse rate. They were, however, unaware of symptoms and signs attendant upon the taking of such medication, such as dilated pupils, tremor and increased sweating, that exposed them as frauds. Others have purged themselves relentlessly in order to cause a tiny external pile to swell up and bleed on the day of the physical. One lad I knew omitted the medication prescribed by a dermatologist for a skin condition for a month before he went, ensuring a delightful rash on the day. Careful questioning by the army doctor caught this man out. One or two real masters of the art of subterfuge, noticing that whenever they smoked "pot" they got wheezy chests, indulged themselves rather liberally in advance of the physical and presented themselves for examination practically unable to breathe. To no avail, however. The draft doctors aren't complete fools. They have noses! Other ruses adopted by "go-it-aloners" include the presentation of symptoms suggestive of epileptic fits—which, incidentally, is a condition very difficult for even a neurologist to discredit. However, these fraudulent attempts are easily enough exposed because of the average layman's complete lack of knowledge of what takes place during the course of a genuine epileptic fit. It should also be pointed out to these gentlemen that, if the ruse had worked and they had been rejected, they would have had a very difficult time thereafter in obtaining a driver's license. They would also have been unemployable in any governmental position until they had been free of "fits" for five years! Such examples should give you pause. And there are scores of other examples that prove just as futile. The simple answer is, don't try to be too smart. Ask your doctor's advice before you go and make a fool of yourself. An ounce of scientific fact is worth a ton of silly speculation.

A word now for fifteen and sixteen year olds for whom the draft seems eons away. In spite of the promises

of politicians to the contrary, it is quite likely that the draft will continue for some considerable time to come. Indeed, there are those politicians who would perpetuate it, and who are opposed to an all-volunteer army at any time in the future. I would therefore advise you to be prepared and to make your plans now. Put every weapon you can in your armory for possible future use.

Here are a few thoughts and suggestions. If you get what is commonly known as a "chest cold" at intervals, then, for goodness sake, spend the few dollars it takes for an office visit so that possible recurrent bronchitis can be recorded on the doctor's records. The same goes for "sinusitis," "hay fever," allergies and skin conditions of all kinds; sprains and swollen joints, and above all, all forms of backache and low back strains no matter how unimportant the condition may appear to you at the time (see section on lumbo-sacral spinal diseases).

You may think such symptoms trivial and unworthy of a visit to a doctor, but the visit and the ailment will be recorded on your medical records and may stand you in very good stead at a later date.

A further word of advice to younger people. If you have a condition which is known to be a reason for draft deferment until it is corrected by surgery, and if such a condition is of no great urgency and poses no immediate threat, then *don't* be a fool and have it rectified. Not for the moment anyway. I refer to such ailments as piles, varicocele (see later), mild degrees of herniae (ruptures), varicose veins and knee cartilage trouble. The list is long, and again, your doctor will tell you which conditions do not present an immediate threat to your health and can wait for remedying which cannot be neglected for too long.

Do take steps to ensure that *all* records of previous illnesses are available to the doctor whom you select to do your pre-draft physical. This can be more time consuming than you realize, for many doctors are rather dilatory in transferring of records. If your draft physical is near at hand, it will pay you to plague (preferably in person)

the offices of doctors and hospitals that have attended you in the past until your records are released. Your signature for permission to release such records will be necessary.

However, try to give yourself plenty of time. You can hardly expect much help if you delay until the day before your draft physical to enlist the aid of a doctor—although even then is better than the day after!

How much will it cost? I am well aware that this is a particularly important question for young people, especially for those supporting themselves through college. The cost of the physical will depend on the individual doctor. The X-rays and other tests he considers necessary in your particular case are certain to cost considerably more than the doctor's fee. Let's say that the cost may vary from a low of about \$10 (the consultation alone), to a high of about \$100 (if you have to have an upper GI series, lumbo-sacral spine X-ray etc.). Charges will vary also, depending on where you live. However, despite rumors to the contrary, doctors are by no means extortionists. They will wait a bit before twisting your arm! And after all, even \$100 is a small price to pay to achieve your object. "What doth it profit a man etc. . . ." if he gets his head shot off in Vietnam?

Symptoms and Signs. This section explains certain terms which will crop up throughout the text. "Subjective symptoms" and "objective findings" are terms commonly used in medical parlance. Subjective symptoms are what you, the patient complain of. Objective findings are what the doctor discovers on physical examination.

There are many instances in medicine when the objective findings back up, and correlate with, the subjective symptoms. For instance: your main complaint (subjective symptom) is of a tight feeling in your chest and a cough which produces yellow phlegm. The doctor listens to your lungs and hears certain sounds which are compatible with acute bronchitis. He may decide to X-ray your chest to confirm his diagnosis. In this instance there is no

argument. The facts are evident and the diagnosis is irrefutable.

Medicine is far from being an exact science however, and every day doctors are confronted with a multiplicity of complaints from patients for which they can find no objective evidence of disease. Examples abound and include such things as dizziness, low back pain, muscular aches in various parts of your anatomy, etc. The examples are legion.

Here is the crucial point. No doctor can deny that you suffer from severe, incapacitating migraine headaches, or that your knee causes you a lot of pain and swells up on occasions. What can he do but believe you, although upon examination he can find no organic reason for your migraine (even with the aid of elaborate tests), and your knee appears perfectly normal.

Yes, you can be quite ill in the absence of any "objective finding," and doctors are acutely aware of this—or should be, in these days of the proliferation of litigations.

PART II

As intimated in the preface, this book is based on a critical evaluation of the various conditions listed in Chapter Two of the government publication *Standards of Medical Fitness* (Appendix C). In case you are not familiar with the full work (and if you are, you certainly have a funny taste in literature), I will briefly describe it.

The complete publication is divided into eight chapters, each of which deals with the medical standards of fitness required by the Armed Forces. Chapter Five stipulates the medical standards required for admission to U.S. military academies; chapter four, standards for flying duties. Chapter Six determines how fit you must be in order to be accepted into the Armed Forces if there is a situation which demands "partial or full mobilization" (if there were a state of national emergency, or the country is at war). In case you didn't know it, however, we are in a state of peace at the moment. As you would expect, the standard of physical fitness required under peaceful conditions is much less exacting than that for total mobilization, though more than those for flying duties. For our part, therefore, we shall stick to Chapter Two.

This chapter is subdivided into twenty-two sections, each listing diseases, deformities and defects in various

parts of the body which render you unfit for induction into the Service.

In the following pages, I have taken the systems of the body one by one, looked at the list of conditions in each one as described in the *Standards of Medical Fitness* (Appendix C), and attempted to explain and interpret what each one means.

The vast majority of the conditions enumerated in these lists apply to gross pathological states and diseases which, should you suffer from any of them, will have been apparent for some time and for which you will certainly have already received medical attention. Most of these conditions I have omitted from consideration, since their very nature and seriousness will automatically exclude you from the draft. I have confined my comments to those conditions which I consider to be borderline, ambiguous, or vague, and I have tried to explain what each means and how it may affect your chances of deferment. I have also given lay definitions of certain unusual medical terms. Simple diagrams are shown where applicable.

Finally, although my comments are directed primarily to the layman, it is my hope that my observations will be helpful to your doctor, especially if he has had little previous experience in examining candidates for the draft.

SECTION II.

ABDOMEN AND GASTROINTESTINAL SYSTEM

"It is a hard matter, my fellow citizens, to argue with the belly, since it has no ears."

—Cato; *Plutarch, Lives*

e. "Gastritis, chronic hypertrophic, severe."

This has to be taken in conjunction with:

7. "Ulcer:

(1) Ulcer of the stomach or duodenum if diagnosis has been confirmed by X-ray examination, or authenticated history thereof."

Chronic hypertrophic gastritis is primarily diagnosed by X-ray in which enlarged "rugae" or folds are demonstrated in the lining of the stomach. Duodenal or stomach ulceration is to a large extent merely an exaggeration of the conditions of duodenitis or gastritis (inflammation of the stomach). Ulcers of the stomach are rare, especially in young people, and it is duodenal ulcer which mainly concerns us here.

As far as you are concerned, the symptoms consist of indigestion with or without pain in the upper central abdomen. The symptoms are commonly recurrent and often associated with nausea and perhaps vomiting. The symptoms come on at a certain interval after meals, and are often relieved by vomiting, taking bland food (i.e., milk), or antacids such as Maalox or Gelusil. The conditions most likely to bring on such an "attack" include: mental strain and fatigue, cigarette smoking, alcohol, highly seasoned foods and such roughage as pips, stalks, and raw vegetables.

If you have ever experienced such symptoms (and who hasn't!), but especially if they are recurrent, you would be a fool not to ask your doctor (and he, not to suggest) that you have a stomach X-ray (barium meal) examination. Doudenal ulcers are pretty common, and if substantiated by X-ray confirmation, will automatically exclude you from the draft.

An important point here. X-rays are no more infallible than doctors, and doudenal ulcers that were not disclosed by X-ray examination have been discovered.

One of the serious complications of doudenal ulceration is bleeding from the ulcer. This may not be in evidence during your attack of indigestion, as it often takes a considerable length of time (one or two days) for the blood to reach the lower bowel and be passed in the stools. By then it is altered in consistency and gives the bowel movement a black, tarry appearance. Such an important event can occur even in the absence of an ulcer on X-ray examination. It can, of course, be caused by other conditions of the gastrointestinal tract. But if you have ever noticed such a black bowel movement, you should by all means inform your doctor. Even if an ulcer cannot be proven as the cause, you will sure as hell pose someone a difficult diagnostic dilemma.

f. "*Hemorrhoids*:"

(1) External hemorrhoids producing marked symptoms."



"Tags" around the anal orifice.



They bulge in little balloons during an "attack."

External hemorrhoids are common even in healthy young adults. They are really a collection of varicose veins located just outside the anal orifice (see diagram). When in a quiescent state, they appear as mere tags of skin around the anus. During an "attack of the piles" however, the tags get filled up with blood, and they may bleed or form clots. They can be extremely painful. Attacks occur at intervals and are usually precipitated by prolonged physical exertion, including standing for long periods, heavy lifting, etc. Constipation for any length of time can bring them on, as can, paradoxically, diarrhea of more than mild degree. The fact that you are not suffering from an actual attack at the time of your draft physical is no proof whatsoever that your life is not a misery at other times! See your doctor and have your attacks recorded and treated as they occur. Even mild piles can cause "marked symptoms," and according to army regulations are draft deferrable.

g. "*Hepatitis* within the preceding six months, or persistence of symptoms after a reasonable period of time with objective evidence of impairment of liver function."

Hepatitis (yellow jaundice) in young adults is usually caused by a virus; contracted either by the common means of contact with an infectious case, or by the less common syringe transmitted route. Injections under the skin or into muscles can cause it, but it is more usually the result of intravenous injections with contaminated needles. This is a common occurrence in those who "main-line" heroin, or other drugs, but hospitals and doctors' offices are certainly not above reproach in this regard.

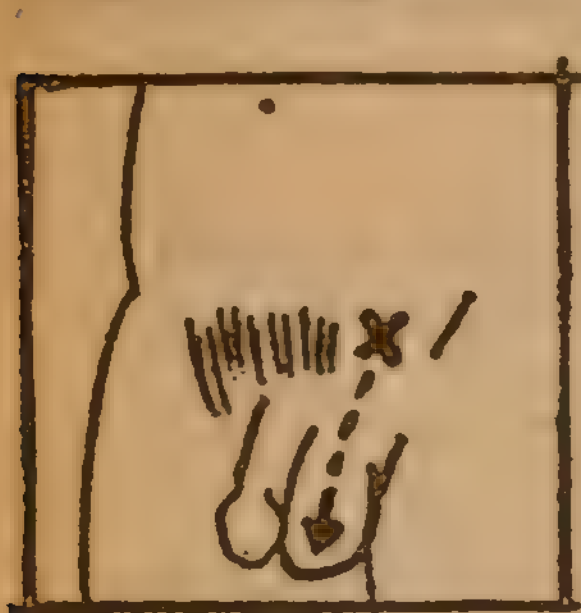
The important phrase in the above quoted army regulation is "objective evidence of impairment of liver function." This can only be determined by a series of blood tests to determine whether your liver is now working properly, or is still affected.

Although not large, the number of cases that continue

to have abnormal liver function tests six months after an attack is nevertheless not insignificant. Your pre-draft physical examiner will doubtless have such tests carried out. Even a relatively minor upset in the workings of your liver may be a bad omen for your future health, but it should at least render you unfit for military service if I interpret the regulations correctly.

h. "Hernia:

(1) Hernia, other than small asymptomatic umbilical or hiatal."



Usual site of bulging of rupture when you cough. The pain often shoots down towards the testicle.



Degrees of rupture: (c) reaches right down around the testicle.

Umbilical and hiatal herniae do not concern us here. By far the great majority of herniae (ruptures) found in young adults are the common inguinal (groin) types. (See diagram.)

The pain associated with this condition is located in the groin, and frequently radiates down into the testicle on that side.

Subjective symptoms loom large here, and I have seen many cases with the merest suggestion of an inguinal hernia that suffered from severe pain on any attempt at strenuous exertion. These were people who had no axe to grind regarding the draft. Conversely, some men, with ruptures bulging right down into the scrotum, suffer from little in the way of discomfort; unless of course, the

blood supply is cut off from the hernial sac and its contents—a condition referred to as “strangulation.” But such an event is an acute surgical emergency, an extreme rarity in young men, and does not concern us here.

Again, what degree of protrusion of the sac through the inguinal ring constitutes a “hernia”? Doctors differ as to what constitutes a “normal” protrusion when the patient coughs, and you may get five different opinions from an equal number of surgeons.

The main thing to remember is that it is *your* hernia. So that if it bothers *you*, holler about it, and let people know!

n. “Scars:

(2) Scar pain associated with disturbance of function of the abdominal wall or contained viscera.”

Such a deformity would be unlikely in a young man unless he has undergone major abdominal surgery for some condition. This in itself would exclude him from the draft in any case.

Nevertheless, an abdominal scar alone in a young person is not such an inconceivable cause of military service rejection as it might appear on first sight. For instance: the surgical incision for removal of a gall bladder can hardly be referred to as “key-hole” surgery. It is certainly no mere nick in the skin, but will be at least four to six inches long—or even more, depending on the aggressiveness and/or ham-handedness of the surgeon. While absence of your gall bladder per se is not usually considered sufficient grounds for rejection, the resulting scar and the disfigurement and pain it causes you can be quite considerable. You yourself are the best judge of this.

SECTION III.

BLOOD AND BLOOD-FORMING TISSUE DISEASE

"God . . . hath made of one blood all nations of men for to dwell on all the face of the earth."

Acts, 17:26

There is a huge discrepancy with regard to the degree of seriousness of the conditions listed in this section. Some, such as dietary deficiency anemia, are of a minor nature and easily remediable, whereas others are serious and often fatal diseases, e.g., most leukemias, and some types of Hodgkin's disease. I shall, of course, confine myself to the "draft controversial" issues. The serious ones will be only all too evident, and should you be unlucky enough to be afflicted with any of them, the draft will be the least of your worries.

a. "Anemia"

Anemia simply means a diminution, for whatever cause, in the amount of hemoglobin in your red blood cells. This thereby reduces the amount of oxygen available to your body. It is not a disease, per se, but follows as a result of some other circumstances. The cause may be as simple as not taking enough iron (necessary for the manufacture of hemoglobin), or it may result from such grave diseases as leukemia, Hodgkin's disease, or myelomatosis.

If your pre-draft examiner suspects that you are ane-

mic, he will doubtless confirm the condition by a blood test and then take steps to determine the reason for it. The causes of anemia are of such diversity that it would be quite impossible to discuss all of them here. This I will leave to your doctor.

There are two conditions in this sub-section, however, which, I think, deserve to be elaborated on:

(4) “. . . *thallassemia*, and *sickle cell anemia*.”

Both conditions are hereditary and are due to an abnormal type of hemoglobin in your blood that doesn't work properly, or causes the red cells to do funny things, leading to all sorts of problems.

Although they are similar “types” of diseases—and even on occasions are found concomitantly in the same individual—as will become obvious later, they must be discussed as separate clinical entities.

Thallassemia (“Cooleys’ anemia”, “Mediterranean anemia”) is divided into two types: *thallassemia major*, and *thallassemia minor*. *Thallassemia major* is an extremely serious disease, and nearly all those who suffer from it succumb before reaching the age of twenty. This is the full-blown disease, which you can inherit if both your parents are affected by the lesser condition, *thallassemia minor*. *Thallassemia major* need not concern us for the above stated reason, but *thallassemia minor* is not uncommon in North America, and is worthy of our consideration.

It is also known as Mediterranean anemia because it is found mainly in those who hail from the Mediterranean littoral, or whose ancestors originated there.

Italy, Greece, Syria, Turkey and the North-African countries bordering on the Mediterranean are all places with a high incidence of the disease, as are the islands of Crete, Cyprus, Sardinia and Sicily. Cases are now being discovered with increasing frequency in those of Indian, Thai and Chinese extraction. Even Northern Europeans

have been found to be affected, as have North American Indians and Negroes.

By now you may be saying to yourself: hell, any one of us could have it; so what possible use is this, and how are we to know anyway?

The answer is that, yes, any of us could be suffering from thalassemia minor and not know it. This is especially true here in the United States, with our heterogeneous population and constant miscegenation. *But*—and here is the reason for including the condition at all—“minor” though the disease is, with few symptoms other than occasional mild anemia, fatigue, and possibly an enlarged spleen, it is nevertheless quite common. One in every twenty-five persons was found to be affected in a survey carried out on Italians in Rochester. Individuals of the above mentioned racial extractions would be well advised to ask their doctor about the advisability of performing a complete blood count examination as part of their physical. This should reveal the give-away “target” cells. If they are present in reasonable numbers, if you are a little anemic, and if he also finds your spleen to be even slightly enlarged, you could have a pretty sound case for deferment.

Sickle cell anemia. This disease is virtually confined to Negroes. No one knows why any more than they can explain the racial predilection of thalassemia. Like thalassemia, it is also caused by an abnormality of hemoglobin, whereby the red cells, instead of remaining normally rounded, become squashed up into crescent (“sickle”) shapes. Cells of this shape are inclined to break up and burst much more easily than normal ones. They also have a propensity for sticking together in clumps in the smaller arteries and veins, cutting off the blood supply to various parts of your body, and thus causing all sorts of problems.

Here again, like in thalassemia, we find the full-blown disease and the partial type (called sickle cell “trait”). Those afflicted with the main disease, like with thalas-

semia major, get such a wide variety of serious complications that they rarely survive to adulthood. Unlike thalassemia *minor*, however, sickle cell "trait" is by no means as innocuous, but is often attended by quite serious trouble, even by death (see later).

How frequently are Negroes affected? Sickle cell disease proper (the serious one) has varied from three to thirteen per thousand in the many surveys conducted among Negro communities in the United States. The figures have varied with different geographical regions of the country. Memphis, Tennessee, can lay claim to the dubious distinction of having the highest incidence of all twenty-five per thousand Negroes found in one survey.

Sickle cell "trait" disease is far more common. Surveys have come up with a low of 8.5 and a high of 13.4 per cent (in S. Carolina). The latter is certainly a significant percentage.

"Trait" disease differs from the main one in that only some of the cells form "sickles," and then only under certain conditions. But, here is the rub—blacks take careful note—it can then cause serious complications. The "certain conditions" (here I must get slightly technical) under which sickling and its attendant dangers have been found most likely to occur are those in which the sufferer is subjected to relative hypoxia. (That's where the amount of oxygen taken into the lungs is less than usual, i.e., at high altitudes.) States of dehydration can similarly precipitate sickling, e.g., if you sweat a lot, have diarrhea or vomiting, and the fluids you lose aren't replaced into your body.

What can happen then? Well, that depends on the number of cells which sickle, the length of exposure to the above mentioned conditions, etc. Any part of your body can have its blood supply cut off by the resulting clot formation. Organs commonly affected are the spleen (causing severe pain in the left, upper part of your abdomen) and the kidney. The latter condition produces pain, and may also produce blood in your urine.

But that's not all! Sickle cell "trait" is a potentially fatal

condition. For those of you who would like more specific information regarding it, I refer you to Schenk, "Sickle Cell Trait and Superior Longitudinal Sinus Thrombosis," *Annals of Internal Medicine*, 60: 465-470, 1964. In *New England Journal of Medicine*, February 5, 1970, p. 323, you can read about the sudden deaths of four Negroes undergoing basic military training between March 1968 and February 1969, on a base located 4000 feet above sea level. Their medical histories revealed nothing remarkable. Nothing could be discovered at autopsy to account for their deaths apart from sickle cell "trait" disease!

Take my advice, therefore, if you're black and are eligible for the draft. Get your doctor to have the appropriate tests performed on your red cells and hemoglobin, even if you appear healthy and have no symptom. There is one chance in ten that you carry sickle cell trait. If he finds "sickling," find a copy of the article I mentioned in any medical library, and take it along to your draft physical. They may still induct you, but if you happen to fall down dead during training, there'll sure as hell be a lot of questions asked of somebody!

This is not the place to go into the treatment of this condition, nor to advise Negroes who intend to marry of the possible consequences to their offspring. Ask your doctor about this. I would observe, however, that most Negroes have never even heard of this disease peculiar to their race. This is a deplorable state of affairs. (Similar sentiments were expressed in an editorial in the January 15, 1970, edition of the *New England Journal of Medicine*.)

b. Hemorrhagic states

These blood diseases, concerning ineffective clot formation, vary in severity from the extremely serious hemophilia, to mild conditions, which merely cause some people to bruise rather easily.

Detailed discussion of most of them is outside the scope, or object, of this book. The clotting of blood is an

extremely intricate and multiphasic process, and many and varied are the diseases which can result from a lack of, or deficiency in, any of the many factors involved. They are the province of the expert in the field.

If, however, you seem to bleed for rather longer than you think is normal, if your nose bleeds easily without apparent cause, or if you are inclined to bruise following trivial injury or knocks against any part of your anatomy, then be sure to mention such matters to your doctor. He can carry out a few preliminary tests in his office. If anything abnormal shows up, you'll be referred to a specialist. If even the slightest defect in your blood-clotting mechanism is brought to light, it will result in your rejection by the military.

f. "*Thromboembolic disease* except for acute, non-recurrent conditions."

Only because of a possible semantic ambiguity in the wording of this description have I decided to give it space.

Thrombosis, as every good American contraceptive-pill taking housewife knows, is a condition in which a clot forms in a vein (or artery) and impedes the flow of blood along that vessel. The "embolic" part of the above long word means that a portion, or all, of said clot detaches itself from the wall of the vein and travels at will all over the place, before coming finally to rest in some other part of your anatomy and maybe causing trouble.

Trombophlebitis, or the simple fact of blood clotting in a vein and staying where it is, is a fairly common condition. It is encountered chiefly in the veins of the calf, and is especially likely to be associated with varicose veins (see later). The calf, however, is by no means the only site of thrombus formation. It can occur in any vein throughout the body. It is often found, for instance, in the veins of the upper arm and shoulder following an injury in that region, and thrombosis of the veins in the

pelvis is very common following certain surgical operations.

Either the veins just under the surface of the skin may be involved, or the clotting may take place in a vein buried deep in the muscles. (This condition is called phlebotrombosis, I hasten to add, in deference to my semantically purist medical readers—the rest of you forget it!) In the common thrombosis affecting the superficial veins of the leg, the first thing you notice is pain and stiffness in that area. Then, when you take a look and a feel, the vein appears as a reddened, tender cord just under the skin. If the deep veins are involved, there may be little pain, but because they are larger veins, the blood coming back to your heart from your foot is stopped to a greater extent. The ankle and foot may become swollen. Though not as painful, it is far more serious than the superficial variety. There is a greater likelihood of the clot becoming dislodged.

Just for good measure, I would like to mention here a fairly rare condition called thrombophlebitis migrans. This, as the name implies (to you classical scholars at least) is a condition characterised by successive thromboses occurring in veins in different parts of the body. There is usually no obvious predisposing cause, and it is usually only found in people much older than you. When doctors encounter this condition, they suspect (or should) a cancer in some part of the patient's body and carry out the various tests necessary to find or exclude it.

So, what have we got, out of all this? Well, if they will settle for the thrombophlebitis itself and not insist on the "embolic" bit, and you can offer proof that on more than one occasion you have suffered such an ailment in any part of your body, then you may have a case.

However, I'm speculating a bit here, and the draft people may well take issue with me and say: "Hold on there, you! Read it precisely as it is written! Two can play your little game!" That is, they may, if they are really mean, cantankerous fellows.

SECTION IV. DENTAL

"Our fathers and ourselves sowed dragons teeth. Our children know and suffer the armed men."

—Stephen Vincent Benet, *Litany for Dictatorships*

Not being a dentist I am scarcely qualified to pass more than cursory comment on the listings in this section. Nevertheless, these guide-lines are issued for the direction of draft *medical* officers, who, should they find evidence of such conditions in draft candidates, then refer them for dental consultation. It is on this basis, too, that I venture to make the following observations.

a. "*Diseases of the jaw or associated tissues* which are not easily remediable and which will incapacitate the individual or prevent the satisfactory performance of military duty."

A wide variety of conditions could be included under this heading, and I suppose it also embraces a mouthful of carious teeth, which you are otherwise reluctant to have taken out. You are a fool, and the resulting halitosis will likely ruin your sex life. Your general health will also scarcely benefit from your lack of dental and oral hygiene. But it's your mouth, and they're your teeth, and it's your decision. Try it anyway. Ask your dentist's advice. After all, you can make up time with the girls even after the age of twenty-six (when you're no longer draft

eligible and have new, gleaming dentures). At least you'll be alive to tell the tale.

b. "Malocclusion, severe, which interferes with the mastication of a normal diet."

My dental colleagues inform me that perfect occlusion (where each upper tooth fits exactly against its lower counterpart, when you take a bite) is very rarely found. Technically, therefore, it might be truly stated that 99.9 percent of us suffer from some degree of malocclusion. The degree of severity, however, is what matters, it seems. Of course, if you have top teeth which stick out a couple of inches further than your lowers, then your malocclusion is obvious and undeniable, and you are probably being constantly made aware of your deformity both by the trouble you have chewing, and the fact that your nickname is "Dracula" or "Fang." Here there is no problem.

Less severe degrees of malocclusion, however, can only be determined by your dentist, who usually takes an "impression" of your teeth by asking you to bite on something.

Be advised by your sympathetic dentist, therefore, but keep in mind that only you, the biter, are really qualified to judge the amount of trouble you have in "the mastication of a normal diet."

d. "Orthodontic appliances [Paragraph 7-12]

"Individuals with orthodontic appliances attached to the teeth are administratively unacceptable so long as orthodontic treatment is required. Individuals with retainer orthodontic appliances who are not considered to require active treatment are administratively acceptable."

Contrary to what is generally supposed, my dental friends inform me, orthodontic treatment is by no means limited to children and teenagers. You could still be a candidate for such procedures, they tell me, even if you

are extremely long in the tooth (and the upper age limit for the draft—twenty-six—can scarcely be called your autumn years, dentally speaking). Consult your friendly neighborhood orthodontist, therefore, and allow him to insert any contraption he deems fit, in or around your tusks. He will surely have to check up on the results of his handiwork at intervals, and meanwhile you're laughing, because of being "administratively unacceptable."

SECTION V. EARS AND HEARING

"The law . . . is deaf, deaf as an adder to the clamors of the populace."

—John Adams, 1770

A word first about *hearing*. Any of the conditions listed in this section can cause a diminution in your hearing capacity—sometimes not to any noticeable degree, as the change may be so gradual as to be imperceptible even by you. As the extent of hearing loss required to render you uninductable isn't all that great, it is obviously important, if there are any doubts about it, that the degree of impairment be accurately measured.

The "whispered voice" test, which most of us nonspecialists use, is a very rough one, and though adequate as a screening test under most circumstances, is open to many misinterpretations and inaccuracies. It cannot supplant the more exacting "audiometric" evaluation.

The former method merely establishes the distance at which you can hear the examiner whispering certain words, e.g., "yesterday," "sixteen," and "William Buckley, Jr." You should normally be able to hear a clear whisper with either ear at a distance of twenty feet, and your hearing ability is then graded. You can imagine that such a test could be open to many inaccuracies, depending on the quietness of the room, how one ear is rendered "closed," the ability of the doctor to whisper clearly etc.

If he has any doubts about your hearing ability, your doctor should refer you for audiometry.

This is a fairly complicated test carried out by equally complicated pieces of equipment. The figures that result are arrived at by such intricate mathematics that it would be impossible to go into them in detail in this context. Indeed, you would almost need to be an engineer to fully comprehend them.

Briefly, audiometry measures the range of your ability to hear, over certain sound frequencies, and expresses it in units called decibels—or to be more specific, in decibel loss through a range of such frequencies.

Even if you have excellent hearing there is some decibel loss (15 dB is usually taken as the base—American Standards Association 1951), and the range extends up to a loss of 82 dB. That's near being stone deaf.

Now, the regulations state that you are excluded from the draft “. . . with hearing level by audiometric test of 20 dB or more average for the speech frequencies (500, 1000, and 2000 cycles per second) in either ear regardless of the hearing level in the other ear.”

You can see, therefore, that you don't have to be far short of normal in order to be ineligible for induction. The inference is obvious. If you or your doctor have any doubts whatsoever about your hearing, then go to an otologist (ear specialist) and have an audiometric test. You may hear something to your benefit!

a. “Auditory canal:

(1) Atresia or severe stenosis of the external auditory canal.”



1. Auditory Canal
2. Eardrum

Atresia

Stenosis

These are rare congenital conditions: atresia (literally, absence) and stenosis (narrowing) of the passage from the outside in to your eardrum (see diagram).

Such abnormalities will have been obvious since childhood, because of the attendant loss of hearing, and I mention them merely by way of definition.

(3) "Severe external otitis, acute or chronic."

These entities refer to inflammation of the canal leading in to, and maybe including the drum, but excluding that part of the ear (the middle ear) at the other side of the drum.

The common causal germ is a fungus, and the infection can often either be initiated or kept going by certain conditions of the scalp, like dandruff or seborrhea. It is a relatively common condition and the chronic variety especially concerns us, because the symptoms (itchiness, perhaps a watery discharge, and some mild hearing loss) can be of such a trivial nature that many sufferers don't even bother to enlist medical aid. They may see the doctor once, be given some kind of ear-drops, and never bother to go back to have it checked. They settle for self-medication if the condition recurs and is mild.

The acute disease usually alarms the patient and sends him to the doctor, because not only is the canal the site of the inflammation, but the discharge can cause a nasty weepy rash on and around the ear. With adequate treatment it usually clears up, but if neglected, it can develop to the chronic type.

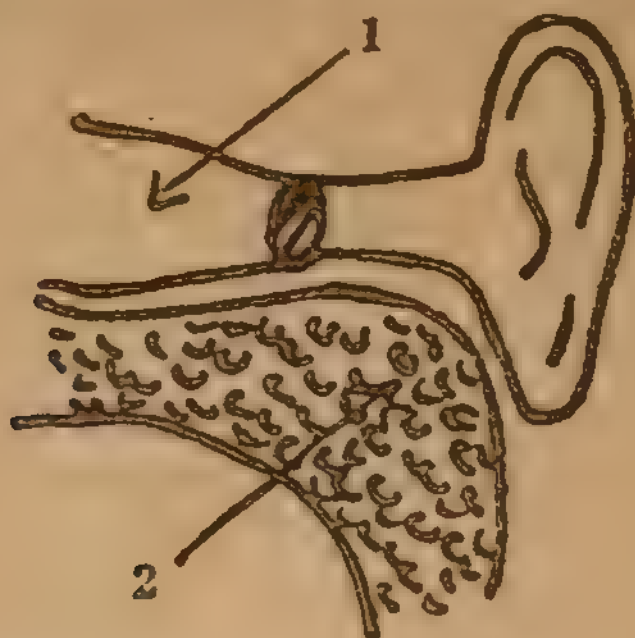
This is characterized by a "smoldering" infection, which never quite clears up and occasionally flares up into an acute attack. In the interval, the symptoms, as described above, may be very mild, but over the months and years the canal may become thickened and gummed up with secretion, and the eardrum thickened with resultant impairment of hearing.

See your doctor, therefore, and have your hearing

tested. Of course, if corrective surgery is indicated, you could always put it off for a while!

c. "Mastoids:

(1) Mastoiditis, acute or chronic."



1. Middle ear cavity

2. Air cells in mastoid bone

These days these conditions are very infrequently encountered. Acute middle ear diseases, which, before antibiotics, used to break into the mastoid bone cells, is now almost invariably brought under control before it goes that far.

d. "Meniere's syndrome."



1. Semicircular canals for maintaining balance

2. Inner ear

3. Cochlea containing the hearing mechanism

4. Middle ear cavity

5. Eustachian tube opening at back of nose

Here we have an important one because the subjective symptoms are difficult to back up with objective findings. Remember?

It is usually a disease of people much older than you (from thirty-five or forty on), and is caused by some upset to the semicircular canals in the inner ear, which serve to maintain balance. (See diagram.) It can take the form of the acute attack (the usual way for it to begin), or become a chronic and relatively constant disability.

If you have ever had such an attack, you will hardly forget it! The ground swims suddenly around you, either to the right or left, or your body seems to rotate in relation to the ground. Your balance goes all haywire and you fall heavily to the floor. There is a loud buzzing in your ear (tinnitus) on the affected side, while simultaneously, your stomach turns into nauseated knots and you may vomit. Don't worry, though. It's never fatal (unless you injure yourself in falling). If you lie still the attack will pass. Your doctor will keep you in bed for a few days, and give you special tablets, and the illness won't usually last for more than a week or so.

No one is certain of the cause, but it is usually attributed to a virus getting into the fluid in the semicircular canals, and messing up the viscosity and hindering the way in which it flows. As it often occurs in epidemics, the virus theory is fairly logical.

With the development of the chronic condition (probably caused by something other than a virus—insufficient blood supply, for example), the attacks recur at intervals. They are not as severe, though, or else people seem to adapt to them. There is a progressive diminution in hearing as time goes on, and as the deafness increases the attacks lessen in frequency and severity. You get out of the frying pan and into the fire, you might say; or vice versa.

Many tests are used in an effort to substantiate a diagnosis of Meniere's syndrome, but none of them is conclusive. You could have it, off and on, without any tests proving positive—except, perhaps, for the diminution in

hearing referred to above. That *could* be due to other causes, but the audiogram often demonstrates a "characteristic pattern" which is suspicious of this syndrome. There is a test called calorimetry. The doctor squirts hot, then cold water into your ears and watches how your eyeballs move. This gives a positive result in a lot of cases.

In conclusion therefore, you *could* suffer from Meniere's syndrome—and quite severely—without any objective findings (the tests). But if it were present for some time, the chances are that the induction doctors would insist on some objective confirmation before believing you. Still, I reiterate, they're *your* ears and *your* symptoms!

e. "Middle ear:

(1) Acute or chronic suppurative otitis media. Individuals with a recent history of acute suppurative otitis media will not be accepted unless the condition is healed and a sufficient interval of time has elapsed to ensure that the disease is not in fact chronic."

Though acute otitis media (inflammation with or without the collection of pus in the cavity of the middle ear) is a relatively common complication of a cold or sore throat or other upper respiratory infection, it is very amenable to treatment with modern antibiotics. Even if a perforation of the eardrum occurs during the course of the disease allowing pus to escape, given the proper treatment, it soon heals again.

However, untreated, or inadequately treated, acute otitis media may go on to a chronic stage. The perforation remains unhealed, and infection recurs with each succeeding cold, precipitating another attack of acute otitis media. An impairment of hearing is an invariable accompaniment of chronic otitis media. It's a real nasty situation and I wouldn't wish it on my worst enemy. You're in a completely different situation though, and your hor-

rible affliction, plus the perforation, plus the hearing defect, will thwart any plans you have of being a soldier!

(4) “. . . attic perforation . . .”



1. Attic perforation: right drum

This means simply a perforation in a certain section of the drum (see diagram), which because of its location is fraught with more complications than if it were situated elsewhere. Apart from the ear disease that caused it in the first place—usually otitis media—it doesn't concern us further.

(5) “Repeated attacks of catarrhal otitis media; intact greyish, thickened drum(s).”

This is a specific type of infection of the middle ear that is often “allergic” in origin. It usually derives from a cold or throat infection in which the eustachian tube at the back of your nose is blocked off as part of the general inflammation. The main symptom is a feeling of fullness, of being “blocked off”, such as you may have experienced if you have ever flown quickly to high altitude in a jet airplane. There is usually no perforation, and treatment is mainly directed towards relieving the congestion in the eustachian tube (with decongestant nasal drops and anti-

biotics, or by actually opening it under direct vision). Repeated attacks, however, or the chronic condition, can cause the drum to be affected from the inside, thickening it, and interfering with your hearing. It will be an obvious condition to your pre-draft examiner, both from your history and on examination.

f. *Tympanic membrane* (Eardrum):

(1) Any perforation of the tympanic membrane."

That's what the man said! If you have a perforation you're out!

(2) "Severe scarring of the tympanic membrane . . ."

Scarring can result from many kinds of ear disease and it is only the accompanying hearing defect which concerns us.

Finally, I think that it is important enough to repeat that an audiometric test is of paramount importance if you have any trouble with your ears, and if you fail to measure up to the standards, that's it!

SECTION VI.

ENDOCRINE AND METABOLIC DISORDERS

"With devotion's visage and pious action we do sugar o'er the devil himself."

—Shakespeare, *Hamlet*, III, i

This group of diseases embraces, almost exclusively, ailments and syndromes, about which, should you have misfortune to suffer from any of them, no doubts can be entertained, either from the point of view of subjective symptoms or objective findings. Generally speaking, they are obvious, undeniable, irrefutable.

Most of them result from a derangement of the endocrine glands in your body, and they are all relatively serious conditions.

As you would require a fairly extensive knowledge of physiology and biochemistry before being able to comprehend a dissertation, however simplified, on most of them, and because, in the present context, the majority are irrelevant, I have limited my comments to the commoner conditions.

c. "Diabetes insipidus."

This disease is mentioned mainly to differentiate it from the much more common and better known diabetes mellitus. It is a condition in which a certain hormone produced in a gland in your brain (the pituitary) is in short supply. This substance normally puts a "brake" on

the amount of urine produced by the kidneys, and its depletion results in the passage of vast amounts of urine, so that you have to drink almost constantly to restore the balance. This is, of necessity, a very simplified explanation, but should suffice for present purposes.

The cause is any process interfering with the proper functioning of a certain part of the pituitary gland, e.g., inflammation, certain rare degenerative diseases, a tumor pressing on the gland, or it can follow certain types of head injuries.

It's a relative rarity, and that's enough about it.

d. "Diabetes mellitus."

Everyone knows about "sugar diabetes," and I hope that I won't bore anybody or insult his intelligence by explaining that it results from an inability of a specific area of your pancreas to produce sufficient (or any) insulin, which, as every schoolboy knows, is the substance that enables the sugar in your blood to be properly utilized and transformed into energy—again an extremely simplified version.

With insulin in short supply, therefore, your blood sugar level rises and spills over into your urine, and all sorts of complications can arise if the disease isn't brought under control.

Diabetes mellitus is, to a certain extent, a hereditary disease, and if it runs in your family there is the chance that, sooner or later, you may develop it yourself. You may be a "latent" or "pre-diabetic"; both are rather unscientific terms, somewhat analogous to describing someone as being a little bit pregnant.

They serve their purpose, however, and when your doctor questions you about your family at your physical, he may decide to have you undergo what is called a glucose tolerance test. This should unmask a "latent" diabetes, and might result in your not being drafted.

The established condition, of course, should you be so

afflicted, will make them shoo you quickly away from all military establishments!

f. "*Glycosuria*, persistent, regardless of cause."

Glycosuria means glucose in your urine, where it shouldn't be, and is therefore abnormal under any circumstances. (Purists may scream: "What about 'lag' and low renal threshold?"; to them I retort that this little effort isn't meant to be a biochemical treatise.)

Many other conditions besides diabetes can be responsible, and whenever glycosuria is discovered, your doctor will also have such diseases in mind, and will, no doubt, try to outrule them as well. It would be impractical and impossible to review them all here. While you are so affected however, "regardless of cause," you remain a civilian.

h. "*Gout*."

This is a disease which is due to an excess of a substance called uric acid in your blood. The immediate reason for this remains unclear (rheumatologists keep quiet!), but heredity certainly appears to play a part.

However, this uric acid changes into urate crystals. These little particles then find their way into the various joints in your body—and to the blood vessels in your heart, and in your kidneys and other organs—where they deposit themselves and cause damage.

Contrary to popular opinion, this disease is not necessarily confined to the gentleman of affluence who lives high off the hog. In my experience, it isn't the exclusive province of any particular class or race—however, males are affected four times as frequently as females—and many a sufferer lives far from baronial halls!

Again, contrary to common belief, the malady is by no means confined to the big toe, although this is the site at which it is usually first brought to the attention of the

sufferer. It is a widespread "metabolic disease," with many ramifications and complications, and mostly any joint or organ in your body may be affected by the noxious urates.

The acute "attack" is typical and hardly needs description. Suddenly, out of the blue, someone is sticking red hot needles into the joint of your big toe, and you writhe in agony. If you happen to have imbibed liberally the previous evening (a common precipitating cause), you make hasty resolutions to go on the wagon forever. Then the doctor comes and gives you a shot or some tablets, and the attack soon passes, and with it your firm resolve.

Even in the absence of classical symptoms, any doctor worth his salt will have this condition in mind when confronted with a male patient complaining of any joint symptoms for which there is no other immediately obvious cause. Unlike the Pope though, doctors aren't infallible. If your symptoms are predominantly in your joints, you may mention, without necessarily offending him, the possibility of your trouble being gout. You would especially be advised to so inquire if you have relatives who suffer from the disease. As a simple blood test is all that is required to confirm the diagnosis, why look a possible gift horse in the mouth?

i. "Hyperinsulinism, confirmed, symptomatic."

Here again is a possible semantic hassle.

Hyperinsulinism connotes an increased output of insulin by the pancreas, which results in a lowering of the blood sugar level below normal limits, a condition known as hypoglycemia (simply, low blood glucose).

Sticking strictly to the definition "hyperinsulinism," we enter the "fine print" realm of medicine. Such an isolated entity is very rare and would only come about as a result of a tumor, or gross increase in size (hyperplasia) of that part of the pancreas responsible for the produc-

tion of insulin. If you have this trouble you're sick, and very unlucky, and the draft needn't concern you.

By hyperinsulinism, however, in medical jargon, is commonly meant any condition which causes a lowering of the blood sugar (glucose) to levels which produce symptoms. Such conditions are many and include such things as severe liver disease, certain rare conditions of the pituitary and adrenal glands as a possible result of gastric resection (removal of a portion of the stomach for ulcers), etc.

By far the commonest entity, causing hypoglycemia and its attendant symptoms, is a syndrome called "idiopathic" (as called "spontaneous," "functional," "alimentary") hypoglycemia, which means that we are not sure of the cause (like so many other things in medicine).

This syndrome is found especially in anxious, agitated, depressed persons, but whether such attributes are primary characteristics or due to the inconvenience and misery produced by their symptoms is open to question.

Among the various mechanisms postulated as the possible cause of the malady is the following. A meal rich in carbohydrates (sugars) quickly reaches that part of the alimentary canal (bowel) which absorbs food into the blood stream. Very efficiently, and rather too hastily, the sugar is absorbed raising the blood sugar level. In response to this (in a sort of "feed-back" manner which you engineers will understand) insulin pours out of the pancreas, with the result that the glucose invader is, as it were, promptly dealt with. Over harshly in fact, and "bang" goes the blood sugar level back down to the low end of the scale.

Then come the symptoms in varying degree. The immediate cause of such symptoms is very fascinating, and a lovely example of the compensatory mechanisms in our bodies and how one chemical constituent balances out the other. Adrenaline now enters the picture and attempts to break down certain complex sugars in the liver (glycogen) in an effort to restore the blood glucose level

to normal, and this excess production of adrenaline is the immediate cause of the symptoms.

The symptoms consist of a feeling of weakness, giddiness, sweating and anxiety coming on at a certain time after a meal—generally from a half, to up to one and a half hours. The pulse is rapid and the blood pressure low, and if the blood glucose falls below a certain critical level, behavioral disorders may ensue. For example, you may act as if you were drunk. Indeed, there have been cases of arrest for drunkenness of persons suffering from hypoglycemia. Most cases, of course, fall far short of this degree of severity.

Let me here again emphasize the importance of a pre-draft physical, with "screening" blood and urine tests where indicated; in the case of possible hypoglycemia, with the taking of a blood sample at the height of your symptoms. But your doctor will be well aware of this.

(1) "Myxedema, spontaneous or postoperative (with clinical manifestations and not based solely on low basal metabolic rate)."

Which statement in itself is reflection enough on the antiquated medical concepts of the services, as only in the "boon-docks" of our profession is "the basal metabolic rate" used any longer as an index of how your thyroid gland is functioning. Much more accurate, and indeed simpler, tests have been available for ages. This test from the army's bag of antiquities belongs to the horse-and-buggy days of medical practice. Leeches are "out" these days too, in case they haven't heard!

Myxedema, or lack of thyroid hormone in an extreme form, will concern but a very small percentage of those of you to whom this book is directed. Only a few of you will have undergone surgery at your age for removal of an over-active thyroid gland. You who have would do well to bear in mind that up to twenty percent (more in some surveys) of people who have had such an operation

end up eventually with a *deficiency* of thyroid, and have to take thyroid tablets for the rest of their lives.

Such a state of hypothyroidism (low thyroid state) may not be apparent, however, for many months or even years after the surgery, and the situation may even arise where you have already been inducted into the service only to have the condition become apparent during your two-year stint. For what it's worth, keep it in mind. If you feel weak and lethargic, have dry, lusterless hair, are constipated and putting on weight, let the army know about it. It'll probably make them laugh until they're sore, but if you keep on complaining and insist on a thyroid test, there's the chance that they'll stop laughing long enough to get rid of you.

It would be much better, of course, to have even a minor thyroid deficiency brought to light *before* the draft, and maybe have the last laugh yourself.

m. "Nutritional deficiency diseases (including sprue, beriberi, pellagra and scurvy) which are more than mild and not readily remediable or in which permanent pathological changes have been established."

Except in Appalachia, and among certain racial and economic groups in the Southern states, it would be unlikely for one to find any of these nutritional diseases in any draftable member of the affluent society. If however, you *do* happen to be *that* emaciated from malnutrition, then, in my opinion, you have every justification for telling them what they can do with their bloody army. And with the country too, for that matter!

SECTION VII. EXTREMITIES

"And he said unto me, Son of man,
can these bones live? And I answered,
O Lord God, thou knowest." (Ezekial, 37:3.)

2-9 "Upper extremities.

a. "*Limitation of motion* . . .

". . . of any joint is almost always the result of disease or injury except for the rare instance of congenital inability to move one or more joints through the range of movement required in order to be eligible for induction."

The figures shown at the back of Appendix C are self explanatory. However, a few definitions which they have omitted or which may be unclear to you follow. Take the elbow joint as an example:

Flexion means the act of bringing your hand up towards your head (like in saluting!).

Extension means straightening out the joint.

Pronation is turning your palm downwards, while the elbow joint itself is held steady.

Supination is the opposite movement, i.e., turning the palm of your hand upwards.

In the lower limb, dorsi-flexion means bending your ankle upwards. Bringing your toes nearer to your knee, in other words. Plantar flexion is the opposite movement.

b. "Hand and fingers:

(1), (2) and (3), Absence of . . ."



1. First

2. Second

and Third phalanges

3. (Note: The thumb has
only two phalanges—
likewise, the big toe.)

A definition only, here. Phalanx (plural, phalanges) is the bone between one joint and another of your fingers, or toes (see diagram).

If you lack any particular one, or combination of these, you are ineligible for the draft. They want whole and entire individuals in this man's army, and besides, if you are missing a lot of fingers or a hand, you can't salute an officer or fire a rifle. Count all of your fingers therefore, and if in any doubt, ask a friend.

(4) *Hyperdactylia* means more than five fingers. Six or more and you're out!

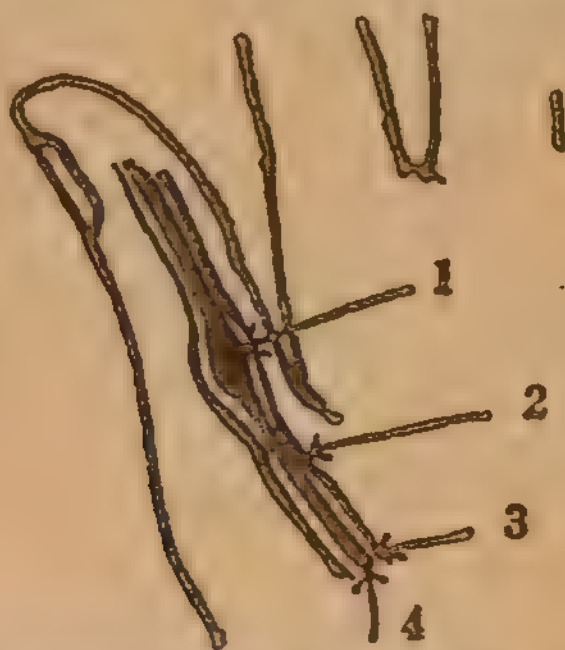
(5) "Scars and deformities of the fingers and/or hands which impair circulation, are symptomatic, are so disfiguring as to make the individual objectionable in ordinary social relationships, or which impair normal function to such a degree as to interfere with the satisfactory performance of military duty."

This could mean virtually anything (werewolves beware!), but even though they don't specifically men-

tion them as entities, I have selected two not uncommon conditions of the hand, which might give you a "fighting" chance.

Stenosing tenovaginitis. No, I'm not going out of my mind! Genital connotation notwithstanding, this condition means a narrowing of the sheath through which the tendon travels which bends your finger. Sorry! (See diagram below.) The cause may be injury or inflammation or what-have-you, and the tendon beyond the narrowed section becomes swollen and has difficulty in getting past the constriction when you attempt to bend your finger (or thumb). When and if it does, it does so with a sudden jerk and a "click," and the condition is known as "trigger finger" (or thumb).

It can be quite a painful condition, and should you be lucky enough to suffer from "trigger finger" in your trigger, or any other finger, or thumb, it can only be corrected by a surgical incision of the sheath. Until you had your operation, you would be unable to be a soldier, which fact might make you very (trigger?) happy.



1. "Compensatory" thickening of tendon
2. Narrowed segment of tendon sheath
3. Tendon sheath
4. Tendon

Dupuytren's contracture. (See diagram below.)

While more commonly found in middle aged and elderly people, this is by no means unknown in youths. It consists of a thickening of the tissues under the skin of

the palm—usually towards the inner side, at the base of the little and ring fingers. It shows a definite tendency to run in the male members of certain families. At one time—and this was even the discoverer's theory—it was thought to result from the repeated pressure and friction to the palm which is peculiar to certain occupations, e.g., carpenters constantly using screwdrivers. That such was not the case, however, became obvious when it was noted that it occurred just as frequently in the left hand of right handed persons—indeed is often found in both hands at the same time—and that it equally afflicts those who have never done a day's work in their lives (convicts, long-shoremen, psychiatrists, etc.).

The thickening becomes worse with time and then contracts, so that the little and ring fingers become progressively more flexed and unable to be straightened out, until ultimately they are completely bent down into the palm.

Such a disfigurement, if of more than trivial degree, should certainly result in the sufferer being rejected for induction, as it would surely "interfere with the satisfactory performance of military duty."



This, I think, is an apt place to quote an Army Medical Directive, dated January 24, 1969.

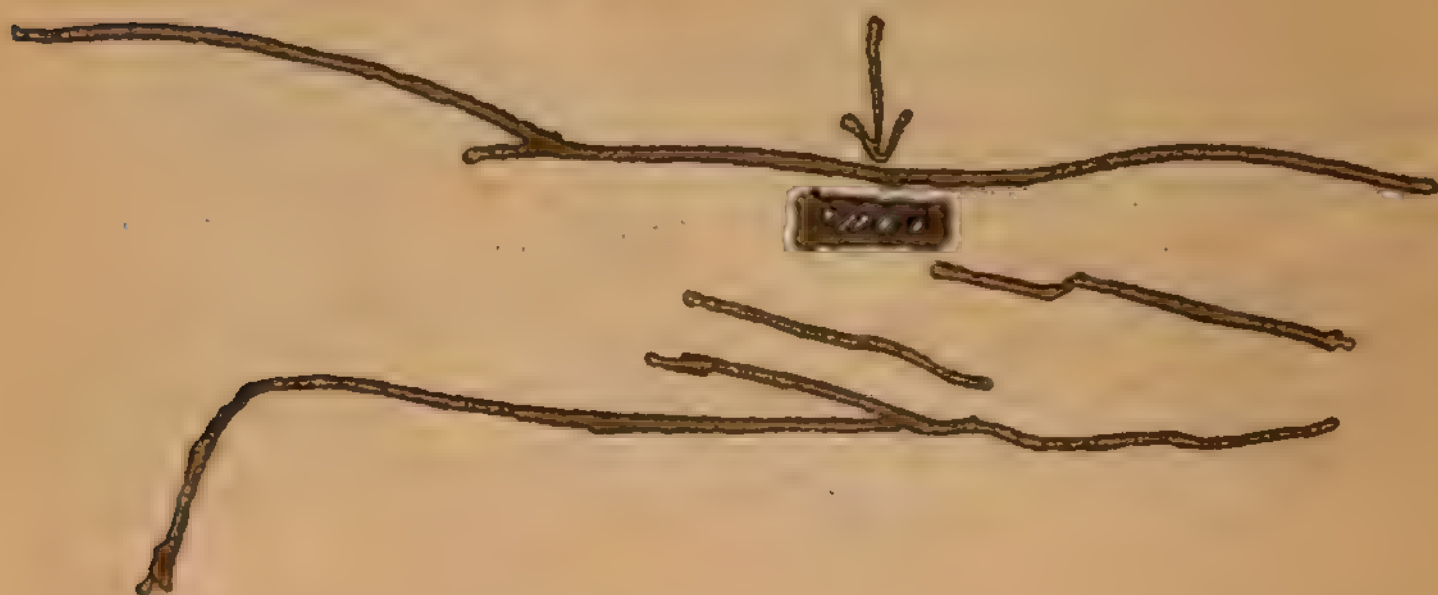
"Examinees who have a physical disability severe enough to warrant 'limited duty' are not qualified for en-

listment or induction. There is no such designation as 'Fit for limited duty' and if examination or consultation reveals a need for, or recommendation of, limited duty, the examinee is medically disqualified."

c. "Wrist, forearm, elbow, arm and shoulder. Healed disease or injury of wrist, elbow or shoulder with residual weakness or symptoms of such a degree as to preclude satisfactory performance of military duty."

Here we have a lovely little disease.

Site of pain in tennis elbow



Tennis elbow is a very common and painful condition. Few of the sufferers have ever wielded a racquet, but the name derives from the fact that the pain associated with it is most easily producible by that movement of the arm when playing an overarm stroke in tennis.

Most of the ligaments that serve to straighten out your fingers, and/or bend back your wrist, are the "thin" ends of a group of muscles on the back of your forearm. These originate on a common site along the side of the bone just above your elbow. (See diagram.)

It can be an exquisitely painful malady, requiring rest, pain-killing pills, and in very severe cases, a shot of cortisone or something similar into the sore spot. The victim is frequently indisposed for a couple of weeks or more. It is notoriously liable to recur and is the bane of the lives

of many. It constantly interferes with both work and play.

Tennis elbow is a disease diagnosed by subjective symptoms only. There are no X-ray abnormalities. The physical sign the doctor looks for is the pain which occurs at your elbow when he asks you to bend back your wrist while he tries to prevent you. He will also expect to elicit a painful response when he presses his fingers into the affected area.

That's tennis elbow then, and if you have it, no one can refute your claims. If it recurs, and you have documented evidence of such recurrences (on a doctor's records), the draft physicians would be well advised to turn you down. They will.

2-10. "Lower extremities."

The same limitations of joint movements apply here as in the upper limb, and the absence(s) of any toe(s) is again self explanatory.

However, one statement in the "limitations of function part baffles me.

(4) "*Toes.* Stiffness which interferes with walking, marching, running, or jumping."

How vague can you get! As stated above, this reason for rejection could vary from severe rheumatoid arthritis to the physiological condition commonly described by millions every day with the expression: "My feet are killing me!"

I really don't know what they mean to be included in the above stipulation, and I have the feeling that neither do they!

b. "Foot and ankle."

Claw foot, club foot, and hammer toes are not very common conditions. If you have them, they will have played a prominent part in your life long before now.

For those of you who may be unsure of how you stand with regard to your feet from an orthopedic point of view, and who for various reasons haven't been seen by a specialist, the army is pretty particular about the state of your "trotters." The draft doctors will spot any gross deformities and turn you down. After all, you have to *march* in the army, in case you didn't know it. In the accompanying diagrams I have attempted to portray some of the conditions in this list. They depict the most extreme degree of each deformity, but will, I hope, help you to decide if you have a similar condition even if to a lesser degree.



1. Claw foot (Pes cavus)
2. Club foot (Talipes)
3. Hammer toe (with Callosity)
4. Footprints
 Normal Flat foot
5. Flat foot (Pesplanus)

(5) "Flatfoot, pronounced cases, with decided eversion of the foot and marked bulging of the inner border, due to inward rotation of the astragalus, regardless of the presence or absence of symptoms."

Flat feet and deferment from military duty have marched together historically. Probably no other medical

or surgical ailment has achieved the fame of this condition in this regard. It stands alone. Nowadays, however, even comedians have abandoned it as a butt for their jokes, but there still exists many an aging gentleman, who when questioned regarding his reasons for survival during the Great War, attributes his good fortune to his feet (flat).

Today, however, a sterner brand of medical inquisitor who gazes with a very sceptical eye on feet purported to be flat has arisen amongst us. Not without good reason either, let it be fairly admitted. In the past, fellows got away with murder claiming flat feet. As can be seen from the above sternly worded definition, the criteria as to the severity of flat feet which will get you rejected by the service are, nowadays, pretty exacting. Don't discard them if you have them, however. They are still far from being a spent force. Complain like hell, and see your favorite orthopedist.

(7) "Hallux valgus, if severe and associated with marked exostosis or bunion."



Severe hallux valgus, with bunion.

Again an excellent, uncomplicated, and not at all uncommon condition with which to avoid the draft. (See diagram.) It has to be fairly "severe," though, and not

merely a slight malalignment. They mention nothing about symptoms, however (pain), and anyway, that's *your* business.

(9) "Healed disease, injury, or deformity including hyperdactylia which prevents running, is accompanied by disabling pain, or which prohibits wearing of service combat boots."

Here come those boots again! Almost anything could be included in this sub-section.

Recently, I examined a young man who had the misfortune to have sustained a fracture of his little toe some years before. The break was long since healed, but the toe stuck out at an angle from his foot, and he had great difficulty in finding suitably comfortable footwear. I had no hesitation in recommending that he be rejected for military service on account of his deformity. He duly was. They're just *nuts* on those boots!

(10) "Ingrowing toenails, if severe, and not remediable."

This condition is very common, and pretty painful too, let me tell you, as I once had such an ailment myself. It may be your own fault to begin with, if you cut your toenail around the corner instead of straight across. The nail then grows in under the flesh and infection often sets in. Even when the nail eventually grows out, the damage has been done and an infective focus initiated. Quite a fair percentage of them become chronic and disabling and a hell of a nuisance to keep under control, even with the help of antibiotics.

A small operation will settle the matter once and for all and you'll have no more trouble, but then you'll be fit and well and . . . !

c. "Leg, knee, thigh, and hip."

Healthy young athletic (out- or indoor) men of the USA, lend me here, your very careful ear!

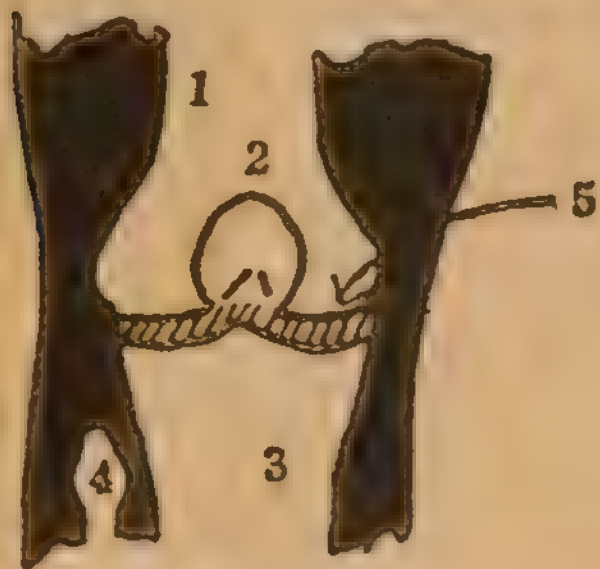
(1) "Dislocated semilunar cartilage . . ."

Read all this carefully, as well as (a) and (b), and *especially* (2). For discussion purposes I will lump them all together.

The knee is a particularly intricate and complex joint, with all sorts of ligaments and things, both surrounding it on the outside, and in its depths. It is susceptible to a wide range of injuries, sprains, strains, insults and diseases, but the ailment of primary concern to us here is what is commonly known as a "torn cartilage."

This is one of the commonest injuries sustained by athletes, and some very famous personages have had their "cartilage out" and their renown thereby enhanced. Weaklings of the world unite, however, and take heart. Who is to know in what "athletic" endeavors you indulge; or where, or with whom or how you came to injure your member!

A twisting injury is the usual way in which a cartilage is torn, especially if at the time of injury the knee is slightly bent and your foot turned out—the "out" refers specifically to the far more commonly torn *inside* cartilage (see diagram)—e.g., swerving at football, skiing



Right Knee—
front view



Right Knee—
viewed from above

1. Femur
2. Patella
3. Tibia
4. Fibula
5. Inside (medial) cartilage, and side of most pain
6. Tear in inside (medial) cartilage

around slalom gates, etc. The possibilities are limitless and should give your imagination wide rein!

When it happens, you get a sudden, sickening pain in your knee and may hear and feel something snap. You seek the ground and soon your knee puffs up like a balloon. It may be "locked" in one position so that you can't move it, even if you felt so inclined.

They cart you off, and the doctor puts you to bed and surrounds the knee with ice packs. He can't even examine it properly until the swelling goes down. This happens within the week. (He may decide to stick a needle into the joint to let out some of the fluid and/or blood if the effusion is more than moderate and you're in dire distress.)

So, you get better, and are soon up and about again, probably with the support of an elastic bandage in the early days of your invalidhood.

What happens next depends on a number of factors, such as the extent of the "tear," and whether or not the surgeon decides on an early operation. (Don't let him! Think about it for a while—at least until you've finished reading this section!) It may "settle," and eventually you resume your athletic pursuits. Then, if the tear is small, you may have little trouble thereafter, apart from occasional discomfort in the knee following strenuous exertion. Such an outcome is unlikely, however, and more probably, you will be plagued with constant trouble in the future.

You might extend the tear in the cartilage, should you duplicate the original accident, with a recurrence of the initial agony. Alternatively, and more commonly, the knee swells up on repeated occasions, as a result of somewhat severe strains. It may "lock," by which I mean that it becomes "set" in a certain position and you can't move it for love or money without causing yourself great pain, or until it "unlocks" spontaneously. It may occasionally "let you down," meaning that it gives way suddenly without warning and you fall over. The latter two possibilities usually result in the knee becoming swollen

again with fluid (effusion) to a greater or lesser extent, forcing you to take to your bed (or chair) for varying periods of rest.

Such then is the possible sequence of events following a "torn cartilage," and the frequency of occurrence of such complications as I have described above is impossible to predict.

Somewhere, sometime, you will eventually encounter an orthopedic surgeon—possibly in an interval between "attacks"; possibly (horrible thought!) the army consultant orthopedist will be the first to examine you. You lie on your back and he looks at both your knees together and compares the sizes. He asks you to bend each knee in turn and then to straighten it out again. He taps over the kneecap to see if there is fluid in the joint; then, with your knee bent, pokes his finger along the middle of the joint to ascertain whether you have any tenderness over the site of the "torn" cartilage (refer to diagram). Then he bends the knee himself, and straightens it out, keeping one hand cupped over the joint to see if he can feel any crepitus (creaking). With your knee straight, he then puts a strain on the inside and outside ligaments along the sides of the knee joint, by first pulling your foot outward and then in the opposite direction, while holding your thigh immobile. This is all routine stuff and is part of any efficient examination of a knee. Then, however, comes the roll of the drums and the audience hushes and he begins his *piece-de-resistance*.

The next test is extremely important and was invented by a chap called McMurray, hence, naturally enough, it is called McMurray's test. It is a pretty accurate way of diagnosing torn cartilages.

The doctor bends your knee to the full extent like before, still keeping one hand over the knee, and grasps your foot with the other. Then, with your foot twisted *outwards*, he quickly straightens out your knee, probably observing your expression as he does so.

Now here's the point of all this detailed description. If the inside cartilage is torn, then, when he performs this

quick straightening of your knee, two things may happen. First, *you* get a sharp pain in the region of the torn cartilage when he gets to about midpoint of the straightening, and *he* may feel (and hear) a sharp crack as the bone in your knee passes over the tear. This is called a positive McMurray's sign and is pretty conclusive evidence of a torn cartilage.

However the doctor doesn't have to hear or feel the crack for the test to be positive. The agonized expression on your face and the *pain you feel* is enough for a positive McMurray. (To examine for a tear in the outside cartilage, McMurray's test is performed as described above, but with your foot turned *inwards* on this occasion.)

Remember, X-rays do *not* reveal tears in knee cartilages, and the knee may appear completely normal. (There is a special X-ray called an arthrogram, where the doctor sticks air or some other substance into your knee joint, which often can show up a tear in a cartilage. You don't have to submit to such a test, however. I wouldn't!)

In conclusion, even in the absence of a positive McMurray sign (or any other signs for that matter), *the diagnosis of a torn cartilage is almost always made on the basis of the history of injury such as I have described above, even though, at the time of examination, the knee may appear perfectly normal.*

d. "General:

(2) Disease or deformity of the hip, knee, or



1. Site of pain and swelling in Osgood-Schlatter's disease.

ankle joint which interferes with walking, running or weight bearing."

There is an entity which I would like to mention at this point, and which is not uncommon in boys between the ages of 13 and 18. It is called Osgood-Schlatter's disease (osteochondritis of the upper tibial tubercle). (See diagram.)

It can follow a fairly simple injury to the knee, whereby the ligaments below the kneecap pull on, and partially separate, a piece of bone from the upper end of your shin bone. It can cause quite a bit of pain, especially when you try to straighten out the knee completely (or the doctor bends it up fully), and it will certainly interfere with your athletic activities at school.

Sometimes it's quite mild, and you (or your parents) may decide that it isn't worth a visit to a doctor. If you have ever had any of the symptoms such as have described, however, see your doctor. An X-ray will clinch the diagnosis.

(3) "Pain in the lower back or leg . . ."

Note! See Section XVIII on spinal conditions.

(4) "Shortening of a lower extremity resulting in any limp of noticeable degree."

Don't try to fake a limp. Physicians have pretty precise ways of measuring the length of your legs. Let your doctor do the measuring and draw the inferences.

2-11. Miscellaneous.

b. "*Dislocation* old unreduced; substantiated history of recurrent dislocations of major joints . . ."

The shoulder joint is far and away the most common site of recurrent dislocations, and I have seen a couple of such cases which had never been X-rayed, or even had

medical attention; the gentlemen involved were able to rectify the deformity themselves, or with a friend's assistance. Rugby football players seem to have a special tendency to such an injury. They seem adept enough, too, at self-induced remedies. However, such unlicensed surgical practice occasionally results in more than the manipulator bargained for; there may result injuries to nerves and blood vessels, and even broken bones.

d. "Fractures."

(3) "Any old or recent fracture in which a plate, pin, or screws were used for fixation and left in place and which may be subject to easy trauma, i.e., as a plate tibia, etc."

If you have ever sustained a fracture which necessitated the insertion of any artificial contraption to promote healing, and such a device is still in place, you won't be accepted by the draft.

A few months ago I encountered a young fellow who had had a plate inserted for a fracture of the lower third of his shin bone. The operation had taken place some six months previously. The bone was soundly healed and the orthopedic surgeon had suggested that the pin could safely be removed. That young man thought otherwise, with the draft coming up. There was no removal of any plate and hence no draft. He feels fine, and he'll be over twenty-six in about five and a half years!

SECTION VIII. EYES AND VISION

“Behold, a king shall reign in righteousness . . . And the eyes of the blind shall be opened.”

—*Isaiah, 32-35*

If last year's pattern is repeated this year, some 12,000 men will be given medical discharges after they have been inducted. Five percent of these, or approximately 600, will be released because they have something the matter with their eyes. An adequate pre-draft eye examination would therefore save a whole lot of people from having to undergo considerable distress and inconvenience, not to mention danger to their lives. I feel certain that such an examination would also reveal an equal number who would be inducted this year and remain for the full two years without their disability being discovered, and many indeed, who shouldn't be anywhere near an army or a gun. Considering this, one can hardly help wondering how much this deplorable state of affairs contributes to so many of the enemy remaining "hidden" in Vietnam! Can the blind lead the blind? Do they not both fall into the irrigation ditch?

The realm of the eye has rightly become the province of the specialist who alone can perform a thorough eye examination. If you have any doubts whatsoever about your vision (and can afford the fee), I would recommend such an evaluation.

Defective vision apart, most of the conditions listed in

this section are self-evident—some all too evident—and draft exclusory by their very nature. I shall touch but lightly on these, and then merely by way of definition. Some are of interest too, if only for being oddities, and these I shall also mention.

2-12. "Eyes.

a. "Lids.

(1) "Blepharitis, chronic more than mild. Cases of acute blepharitis will be rejected until cured."

This not uncommon condition means an inflammation of the edges of the eyelids along the line of the eyelashes. The lashes become chronically stuck together at their bases and constantly produce matter which falls off in "flakes". It is troublesome as well as being unsightly, and needs no specialist to diagnose. If it is "more than mild"—and that's for *you* to say—it is draft exclusory.

(2) "Blepharospasm" means involuntary contractions of the muscles around the eye. It is usually confined to one side. You've probably seen the condition in certain nervous individuals, and might even, to your embarrassment, have interpreted the affliction as a wink. Much misunderstanding has always been associated with this condition. That is probably why they have listed it as a cause for deferment. Soldiers must often go for long periods without female company. Much annoyance and trouble might accrue from someone rushing around winking at everybody. And think of what might happen in the navy!

(8) "Lagophthalmos" is a condition which means that your eyelids never quite close, not even when you're asleep. It is a rare condition, the causes of which aren't worth discussing here. I don't know why they keep fellows like this out of the service. By all accounts they need people around who keep their eyes open!

(9) "Ptosis, interfering with vision."

Ptosis, or drooping of the upper eyelids, may affect one or both eyes and can have serious or simple causes. Many army sergeants have it, especially when ignoring the black-market activities of a colleague. Even Robert Mitchum got in.

b. "Conjunctiva.

(1) "Conjunctivitis chronic . . ."

Not unlike blepharitis, except that the infection is located on the insides of the eyelids rather than along the margins. Often the conditions coexist. It is common, and often endured by the patient without seeking medical aid. If you have it though, show it to every doctor in sight.

(2) "Pterygium . . ."



1. Pterygium

. . . is quite rare. It consists of a sort of brownish tissue which grows out like a wedge towards the pupil from one or other corner of the eye. You'll notice it alright if you have it, and you can read (can't you?) the stipulations which render you and your pterygium ineligible. Seriously though, you will hardly be inducted if you suffer from this condition, but make sure that the doctors at your draft physical know about it. Some of those gentlemen also suffer from very poor vision!

c. "Cornea."

The cornea is that transparent part of the "skin" of your eye covering the "hole" that is the pupil. Should that become "filmed" (opaque) for any reason you have a problem. But not with the draft.

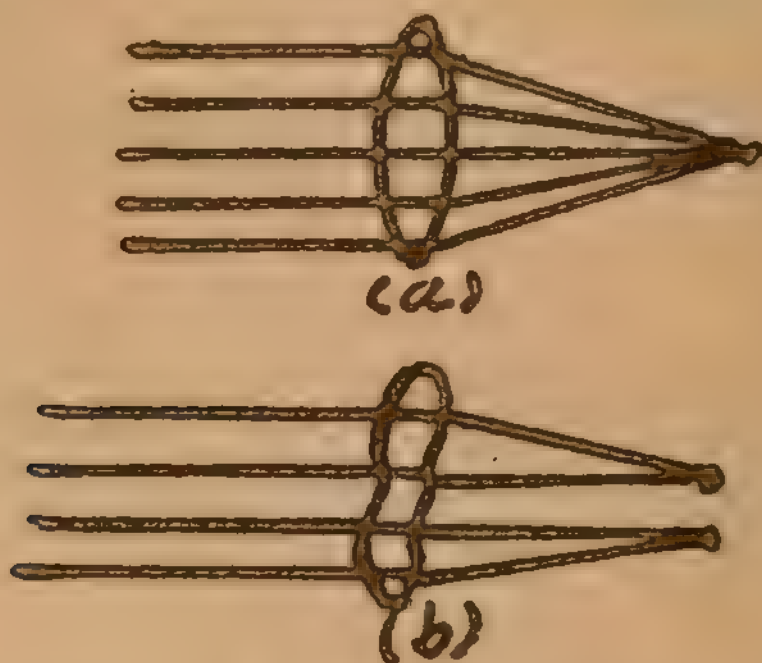
d., e., f., g.; Diseases of the uveal tract, retina, optic nerve and lens are, in the main, serious conditions, many of which lead to permanent blindness. They have no part in this treatise.

b. "Ocular mobility and motility.

(1) "Diplopia, documented, constant or intermittent from any cause . . ."

If every time you "couldn't see straight" you went to the doctor, you'd end up in the poorhouse. Anyone with genuine double vision, however (where you can see two images at the same time), should beat a quick track to his doctor. It would be impossible to discuss all the causes of diplopia in this context, but they can range from as serious an entity as a brain tumor to such simple causes as a mild squint or more than three high-balls.

(2) "Diplopia, monocular . . ."



For years I used to wonder how you could see double out of only one eye. So ignorant did I feel that I never

had the nerve to ask. Then I plucked up courage and asked another doctor and he didn't know either. Time passed, and I discovered that we have in our midst a whole heap of doctors who had never even heard of the condition and were even more ignorant than myself. I took the trouble to find out though, and will herewith let the whole world in on the secret.

It has to do with the lens, you see. The normal lens is oval and smooth, and gives you a nice, clear, true image on the retina (*a*). If, however, the lens, for any reason, becomes distorted and knobbly and generally out of shape, you can get all sorts of things projected onto your retinal "camera," and can indeed get two images at once (diplopia) (*b*), and maybe more. You'll maybe get the picture more clearly if you have ever tried to pick out which of the three identical chaps was your friend, after one or two "over the eight" in a pub. Try it next time with one eye closed. You may see nothing at all and end up flat on your face. But if the three of him becomes two, that's monocular diplopia, drunk or sober.

i. Miscellaneous defects and diseases.

(2) "Absence of an eye". Lord Nelson would never make admiral today!

(3) "Asthenopia severe."

Asthenopia is what I have right now after typing thirty pages today. It's eye strain, purely and simply, and is one of those vague, indefinite entities over which you could argue for hours, and which, if taken at its face value, would render nearly everyone I know ineligible for the draft.

The symptoms include a "heavy" feeling around the eyes—you can hardly keep them open. They may ache a little and a tear or two may fall at times. You may see double, and the muscles around your eyes could start to twitch. You're worn out and it's time you went to bed.

If you manage to be rejected by the service with the

above diagnosis stamped on your records, I'd sure as hell like to know the address of that particular draft center!

(9) "Night blindness associated with objective disease of the eye. Verified congenital night blindness."

If someone tells you that if you stop eating carrots for a year you'll be a cinch to beat the draft, forget it! And don't bother yourself staggering about after dusk, muttering: "I'm blind! I can't see a thing!" etc. They have tests for that as well. Anyway, all draft physicals are held during daylight hours, and they'll hardly stay on after dark to test *your* eyes.

It is, of course, rather rare to find true night blindness, and apart from the congenital variety, it is almost always caused by other eye conditions (some very serious), e.g., optic nerve atrophy. Of interest is the fact that it is a not uncommon entity in the tropics, presumably as a result of frequent exposure to bright sunlight. Some countries (Russia) show a high incidence, and it is found more frequently than one would expect among the inmates of institutions such as jails and asylums. (Whether or not Russia and such institutions have any common factor is open to conjecture.) Vitamin A deficiency if severe is a well known and authentic cause. Maybe little Russian boys won't eat their vegetables either!

2-13. "Vision."

Here we come to the "nitty gritty", the cause of most draft rejections for eye defects.

Every doctor has charts and things in his office to test your near and distant vision. Such tests are simple and quite adequate for estimating your visual acuity, and you either measure up to the standards required for the draft, or you don't. Consultation with a specialist is unnecessary except in borderline cases. Refraction is a different matter entirely though. (See below.)

You draft candidates can go and take a rest at this

junction. The following few paragraphs are directed mainly to your pre-draft medical examiners and contain direct quotes from certain army medical directives which are *not* included in Appendix C.

Medical Regulations—Directive of January 24, 1969.

9,b. "Although the over-all EPTS rate (existing prior to service discharge rate) remains relatively low, an increase in the number of eye conditions and defective vision has been noted. Particular care should be given this portion of the examination and consultation with specialists should be obtained where indicated."

8,b. "Examinees whose uncorrected distant visual acuity is in excess of 20/200 in one eye, as determined at AFEES, should have a consultation to determine their refractive error, even though their vision may be within the acceptable standards. However, if the individual has in his possession suitable lenses (not contact) which correct his vision to better than 20/200 in the defective eye, a consultation is not necessary."

8,c. "In all cases involving examinees who wear contact lenses and a refraction is required in Item 60, SF (Standard Form 88, a form used at the induction center for physicians examining registrants), the medical officer should make a statement in Item 73, SF 88, to the effect that contact lenses were removed for 72 hours prior to the refraction."

8,d. "Color blindness, per se, is not a cause for rejection except in cases where indicated for specific programs."

And for ophthalmologists:

8,a. "Any degree of refractive error in spherical equivalent or over, -8.0 or $+8.0$ diopters is a cause for medical disqualification."

8,a.(1) "Spherical equivalent is obtained by algebraically adding the refractive error of the sphere and one half the refractive error of the cylinder. Examples: (1) $+8.0$ sphere and $+1.0$ cylinder would be $+8.5$ spherical equivalent; this would be disqualifying. (2)

+8.0 sphere and -1.0 cylinder would be +7.5 spherical equivalent; this would be medically qualifying."

c. Refractive error.

Like audiometry, tests for refraction involve all sorts of complicated apparatus, not usually found in the nonspecialist's office.

Briefly, it has to do with estimating whether your eyeball is too short (hyperopia), or too long (myopia), and testing your lens for regularity or irregularity (astigmatism). The specialist will also test the ability of the lens in your eye to "adapt" itself to looking at objects far away and near at hand. This is called "accommodation." Your "fields of vision," or the ability to see things "out of the corner of your eye" will also be charted. You can see then that it's a pretty involved process.

I won't elaborate further except to say that the standards of refraction required are fairly exacting so that if you or your doctor have any doubts about your vision, especially if you wear glasses, a visit to an ophthalmologist might pay rich dividends

SECTION IX. GENITOURINARY SYSTEM

"Therefore behold I . . . will cut off from Jeroboam him that pisseth against the wall . . ."

—*Kings*, Book 1:14

2-14. *Genitalia*

Women have the edge on us here, susceptible as they are to a wide variety of ailments in these organs, which we escape. Nevertheless, we have a few little troubles of our own which can cause a lot of bother. However, there is a certain justice about life. One thing balances out another, as it were. What you may have up to now looked upon as a nasty affliction, and a hell of an embarrassment, could well prove to be to your advantage. Job's comforter, you may say I am. It's OK for me to talk, you say! *I* don't have to suffer the shame! Well, hell, I'm trying, am I not?

m. "*Testicle (s)*. Absence or non descent of both testicles."

"*Testiculos habet et bene pendentes*," the cache of cardinals used to declare in the Middle Ages, when they would have interviewed a candidate for the Papacy. That particular chap would still be in there with a fighting chance of being elected—at least, in any case, not turned down out of hand. Alternatively, they might issue the

following bulletin about the lad: "Testiculos qui no habet, Papa esse non potest." And should you now substitute "soldier" for "Papa," the same holds good even to this very day, as far as the draft is concerned. (If you never took Latin, one of the local clergy will help.)

If you haven't any—and even if you have, and they're not immediately producible—the army doesn't want to know about you. You may not be laughing, but at least you're out!

(3) "Undescended testicle."

Because of the chance, albeit small, of an undescended testicle becoming the site of a malignant growth, it would be rare to find men of your age who would not already have undergone an operation for the correction of such a condition, once it had been diagnosed. This is an instance where I would *not* recommend deferring surgery for beating the draft. If you have an undescended testicle go and see your doctor, and follow his advice, even though he *does* suggest an operation.

Incidentally, as I read the regulations, if you have only one testicle, and it's descended, you're still eligible for the draft. (They don't mention three or more!)

q. "*Varicocele or Hydrocele, if large or painful.*"



Here is included a condition, which in certain circles might be described as a *lulu* of an ailment as far as the draft is concerned. Varicocele ranks way up there in the historic echelons—almost on a level with flat feet and varicose veins—as a means for avoiding military service.

It is a condition in which the veins running along the spermatic chord (see diagram) are in overabundant supply, and are twisted and dilated and form a definite lump, just above the testicle in the scrotum. This *may or may not* produce symptoms.

Men who have had little chance to make comparisons with their fellows (most of the human race), and in whom I discover this condition and make comment on it, have no idea what I'm talking about. For most of their lives, of course, they have been aware that such was the state of affairs in their scrota, but have never considered it to be abnormal. Indeed, if they have ever thought about the matter at all, it was only to decide that they were rather better endowed than their fellows.

Between puberty and the age of thirty-five, around 5 to 10% of males have some degree of varicocele, 90% of which are located on the left side. Some 10% of those afflicted have also an associated inguinal hernia on that side.

The vast majority have no symptoms and the condition is merely an incidental finding on a routine clinical examination. It is often evident on inspection alone, and the testicle on that side is usually seen to hang lower than normal. When felt between the fingers, it gives the impression of handling a little bag of worms. It is rarely tender to the touch. Often, the testicle on that side is discovered to be smaller than usual (perhaps because of interference with its blood supply).

Symptoms, when present, consist of a dragging pain on that side, often extending upwards from the swelling and down into the testicle. This pain can be quite severe on occasions, especially after strenuous exertion, standing for prolonged periods, any type of straining and—Vietnam candidates note—such symptoms are always aggra-

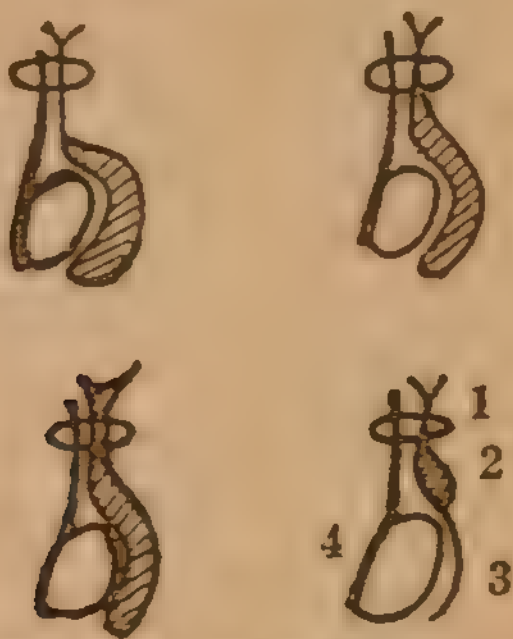
vated in hot climates. (I have one patient who has no trouble at all when wintering in upstate New York. When he comes to California during the summer, however, he suffers agonies!) It is the thin, rangy individual who is more likely to have symptoms than the short, fat one.

In summary, 10% of you may be afflicted with varicocele, and for all anyone knows—or can prove anyway—all of you who have it suffer untold torture. Need I say more?

A simple operation will effect a permanent cure, but . . .

Hydrocele, though not as common as varicocele, is nevertheless, a fairly frequently encountered condition. It consists of an accumulation of fluid somewhere along the course of the spermatic cord. This accumulation can vary considerably both in size and location. (See diagram.) The only complaint from the possessor is of the presence of a lump. Indeed, especially in young people, “complaint” is scarcely a happy choice of words. Rather, it is more frequently a source of pride. Pain and discomfort *may*, of course be present, especially with large hydroceles. This, as usual, is entirely “subjective.”

Two treatments are available. You can have it



Degrees of Hydrocele

1. Inguinal ring
2. Hydrocele
3. Spermatic cord
4. Testicle

“tapped” (aspirated with a needle) in the doctor’s office, or have it removed surgically and be done with it forever. But, again . . .

s. “*Major abnormalities and defects of the genitalia such as change of sex . . .*”

Transsexuals are out! And a good thing too!

2-15. Urinary System.

a. “*Albuminuria* if persistent or recurrent including so-called orthostatic or functional albuminuria.”

This is an important condition for us, the more so because the higher-ups considered it worthy of a special Medical Directive on Jan. 22, 1969. (Pre-draft examiners note.)

13. “Albuminuria, if persistent or recurrent including so-called orthostatic or functional albuminuria is medically disqualifying. The persistent or recurrent (two or more in a three-day urine series) finding of a 1+ or higher reaction for protein using the ‘lab stick’ test for urinary protein will be considered disqualifying. The Surgeon General is of the opinion that the standard governing albuminuria must be rigidly applied unless it is feasible to accomplish the following:

a. “Have the individual undergo a complete medical evaluation including well documented renal function studies.

b. “Three 24-hour urine protein determinations to establish the degree and reproducibility of the proteinuria. If the 24-hour QUANTITATIVE urinary protein determination results in values of 20 mgm% or higher, examinee will be disqualified.

c. “Refer the entire medical record to the Surgeon, USAREC, for review and waiver consideration.”

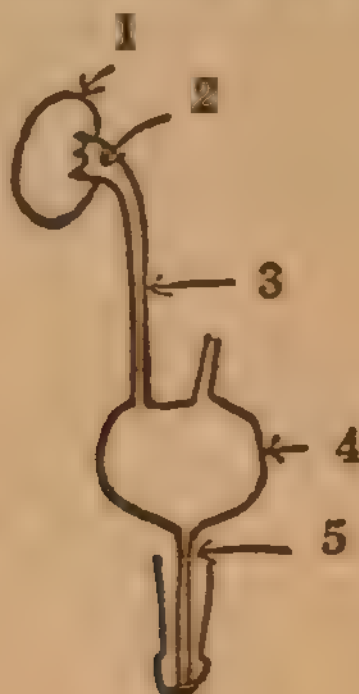
Albuminuria means the discovery of albumen (a type of protein) in your urine, where it should never be

found under "normal" conditions. There are about a million things which can cause it—some extremely serious (nephritis), some trivial (a mild infection)—and sometimes, especially in young men, no cause can be found. It is then called "orthostatic" (only present when you are standing up) or "functional" (we don't know the cause!). When present it should always be investigated.

But, the "lab stick" test which they employ to test urines at the draft physical is notoriously unreliable and "false positives" are common. (The only way to obtain a specimen uncontaminated by secretions in and around the penis is by passing a catheter into the bladder, and you're hardly going to submit to that!) "Contamination" at the draft center isn't always accidental though, and I heard recently about a fellow who added a little chicken broth to his specimen and got off! To quote Churchill: "Some chicken! Some neck!"

They're a pretty busy bunch at the draft center, you see, and directives from on high notwithstanding, they are very likely to take the easy way out and give you a IY classification, if albuminuria is discovered. They're only human too, after all!

a. Cystitis chronic." Individuals with acute cystitis are unacceptable until the condition is cured.



1. Kidney
2. "Pelvis" of Kidney
3. Ureter
4. Urinary bladder
5. Urethra

This will be discussed in conjunction with *g*, (6) "Pyelitis," and *m*, (2), "Urethritis," (see below), because each condition is merely an extension of, and may coexist with the others. (See diagram.)

Women are much more commonly afflicted with "cystitis," and there can be few females anywhere who have reached the age of thirty without suffering from some degree of urinary tract infection. It is far from being uncommon in males either.

The symptoms of what is commonly called cystitis consist of having to urinate frequently, which act produces pain and "burning" along the pipe (urethra: Urethritis). Even when it is obvious that the bladder must be empty, the desire to urinate may still persist (strangury). The urine may be cloudy and occasionally tinged with blood. In severe and/or untreated cases, the infection may travel up the ureter to involve the pelvis (Pyelitis) of the kidney, or even the kidney substance itself (Pyelonephritis).

The condition is fairly easily brought under control with the various antibiotics available to us nowadays. Nevertheless, it is still notoriously liable to recur.

As for "objective findings," the only physical sign elicitable by the doctor—apart from a possible rise in temperature—is tenderness over the bladder and on pressing in the region of the kidney, if it is also involved. Even tests on the urine provide little in the way of conclusive evidence that you have such an infection. A little albumen may be present, and under the microscope may be seen an increase in the number of white and red blood cells and some of the responsible germs. Seeing, however, that such findings are often discovered in the urine of "normal" people, this test is far from being conclusive. Indeed, even when the urine is sent to a laboratory for culture ("growing out") of the offending organisms, you can get as many "positives" from those without, as with symptoms.

If you have any of the above "symptoms" therefore, have them recorded by visiting your doctor—as fre-

quently as takes your fancy. Take my word for it, it's a heck of a condition to pronounce as "cured"!

c. "*Enuresis* (bed wetting)." See Section XVI.

d. "*Epispadias or hypospadias* when accompanied by evidence of infection of the urinary tract or if clothing is soiled when voiding."

Hypospadias (a common congenital condition occurring in 1 in every 350 males) and epispadias (not so common; 1/30,000) are conditions in which the urethral (pipe) opening isn't located at the tip of the penis, but somewhere underneath the shaft (hypo) or along the upper surface (epi).

Many cases of hypospadias are never discovered because of the sufferer's embarrassed reluctance to reveal it, or because he considers it normal. Take a good look at yourself tonight, with the aid of a mirror if necessary.

g. "*Kidney*."

Some of the conditions listed here have already been discussed. The rest, except for (1), absence of a kidney, are serious, life-threatening maladies which will not be discussed here.

h. "*Penis* amputation of . . ."

Ouch! If such is your plight you have my deepest pity. But let's face it. It renders you of little use to man, or beast, or the army.

k. "*Renal calculus*."

(2) "Verified history of renal calculus at any time with evidence of stone formation within the preceeding 12 months, current symptoms or possitive X-ray for calculus."

If you have ever had a renal calculus (stone in the kidney) you won't forget it in a hurry and will undoubtedly

have sought medical assistance at the time. The pain is sickening; felt in the back over the kidney, from which it radiates around to the front, down, even into the penis or the testicle on the same side. It comes on in waves, varies with the position you adopt. Such is its intensity that it can make you sweat or even vomit. When next you pass urine, it may contain blood.

The subsequent outcome could be any of the following. The agony persists unabated, an X-ray shows that the "stone" has not moved, and the surgeon has no option but to remove it by the appropriate procedure. Or, the "stone" passes down along your "plumbing" system, reaches the bladder and stays there. Finally, it may break up and be passed in the urine.

Three points should be emphasized. (1) Many people experience this condition in a mild form and the "stone" passes and they never see a doctor. Your medical *history* is therefore of paramount importance. (2) "Stone" is often a misnomer as the condition can just as easily be caused by a "lump" of anything else, e.g., a blood clot, a mixture of blood and bacteria, or the various other flotsam and jetsam passing through the kidney. An important predisposing cause is severe sweating, or any other dehydrating condition leading to concentrated urine. (3) Most of the "stones" aren't visible on X-rays; so here we are, back with the history and "subjective symptoms" again.

SECTION X. HEAD AND NECK

"If you can keep your head, when all about you are losing theirs . . ."

—Rudyard Kipling

2-16. "Head

a. "*Abnormalities* which are apparently temporary in character resulting from recent injuries until a period of 3 months has elapsed. These include severe contusions and other wounds of the scalp and cerebral concussion."

If you have suffered a recent head injury of sufficient severity as to necessitate your having had to attend the Emergency Room of a hospital, then they won't bother you for a period of three months; which is extremely generous of them, don't you think?

Contusion simply means bruising, and the "severity" is in the eye of the beholder. However, cerebral concussion merits further consideration.

Depending on the amount of force involved when you get banged on the "nut," you may merely experience a momentary display of mental fireworks, or, at the other end of the scale, be in a coma for the remainder of your life. In between are all degrees and durations of interference with consciousness, extending from loss of memory about the accident and the events leading up to it (retrograde amnesia), to being "blacked out" for a time after

the event. You may even continue with what you were doing before the injury, and ostensibly act normal, but remember nothing when you later try to recall it. Such a sequence of events is very common in head injuries sustained at football playing.

Unless, therefore, you are a bit on the dim side, you can see that "concussion" is very largely a "subjective symptom." *You and you alone* are aware of the extent to which the injury affected your consciousness.

Late results of head injuries:

Regularly attending my office at the moment are two patients who suffered head injuries of moderate severity, three years and one year ago, respectively.

Neither showed any signs of a fracture in skull X-rays taken at the time of injury. Both complain bitterly of severe, recurrent headaches and dizziness and vie with each other in the bizarre nature of the other horrible things which keep happening to them. One sometimes sees frightening flashes off colored lights and suffers from the *déjà vu* phenomena (that is the feeling under certain circumstances that "all this has happened before"). The other "can't seem to concentrate for more than short periods" and has funny and unpleasant sensations of smell and taste.

Each has been seen by a neurologist, and in a hospital has been given a full "work-up," including a spinal tap, EEG (electroencephalogram), repeat skull X-rays, and even a brain scan. This is a special test whereby a certain radioactive substance is introduced into your blood stream, settling finally in the brain substance where it is then "scanned" with a geiger counter to see if all parts of the brain are equally permeated by the substance (normal) or not (abnormal). None of these elaborate tests revealed any pathological entity to account for their symptoms.

But, can I, dare I, say that they are making their symptoms up? That they don't, in fact, experience the feelings they recount? Of course I can't, and neither can

anybody else. Both have been officially classified as disabled.

b. "Deformities of the skull in the nature of deformities, exostoses, etc., of such a degree which would prevent the individual from wearing a gas mask or military headgear."

Here we probably grasp at straws as far as the vast majority of you "normal" fellows are concerned. Only the "etcetera" part of the above definition could be of any doubtful significance, and from that vague limbo I have picked the following.

Sebaceous cyst(s) of the scalp or thereabouts can grow to the size of a duck-egg. If you are the possessor of such a foul deformity, you can now gain solace for all the rotten names and cat-callings to which you have been rudely subjected in the past. After all, you can hardly wear a military cap with comfort, can you? Or a helmet, or a gas mask? And it often gives you headaches, doesn't it?

c, d, and e are self explanatory, serious, and very obvious, and I won't dwell on them.

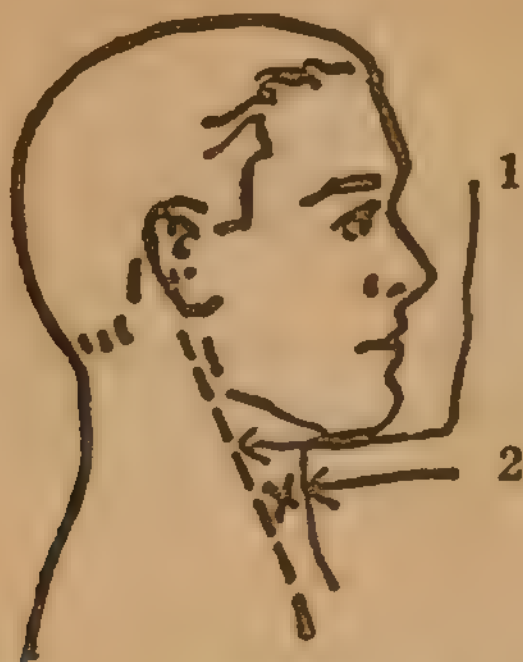
f. "Unsightly deformities such as large birthmarks, large hairy moles, extensive scars, and mutilations due to injuries or surgical operations; ulcerations; fistulae, atrophy, or paralysis of part of the face or head."

Though acquaintances of yours may have voiced the opinion on occasions that your whole head leaves a lot to be desired from the aesthetic standpoint, that won't "cut any ice" with the draft people. You might be ugly as sin and still not be in the same league with some of those master sergeants!

The relatively common Bells' palsy (facial paralysis) is included under this heading. Even if only a mild degree it will still exclude you from the draft. You'll know well if you have it. Your girl friend will surely have mentioned it.

2-17. Neck.

b. "*Congenital cysts of branchial cleft origin or those developing from the remnants of the thyroglossal duct, with or without fistulous tracts.*"



1. Anywhere along this line could be the site of a Branchial cyst.
2. A thyroglossal duct cyst is almost invariably located in this position.

Branchial cysts and cysts of the thyroglossal duct are rare developmental abnormalities and are mentioned in this context only because they are often confused with other "lumps" in the neck. They are often quite small, causing no symptoms, so that they might never be seen by a doctor or be identified for what they are (things that will get you out of the draft!).

Branchial cysts are located to the side of the neck and thyroglossal ones invariably in the middle line. (See diagram.)

Each appears as a smooth, rounded, tense, non-tender swelling and can be of any size. Occasionally the cysts have a communication with the surface of the skin along a track called a fistula. Through this opening the watery contents of the cyst may discharge either intermittently or at intervals, and germs may track along the fistula setting up infection or even an abscess of the cyst. These complications of the cyst will have driven you to the doctor long ago. It's the small symptomless ones which concern us because of their similarity with a multiplicity

of other small lumps which can occur in the region of the neck and which do *not* exclude you from the draft.

See your doctor if you have such a lump and let him make the diagnosis.

g. "Tumors of the thyroid or other structures of the neck."

Everyone has seen, or at least heard of, the condition known as a goiter. "Puberty" goiter, even at your advanced age, is not uncommon, and while posing no problem as regards your health, if large enough, it could render you uninductable. Again, let your doctor advise you.

SECTION XI. HEART AND VASCULAR SYSTEM

"Who shall ascend into the hill of the Lord? . . . He that hath clean hands and a pure heart."

—*Psalms*, 24

On reading the first word of this section heading, you might be forgiven for asking yourself the question: What in God's name do they mean: "Heart"? Surely, you may have thought to yourself, anyone suffering from a heart condition is hardly fit to be up and about, let alone to go off fighting a war in Vietnam. What an asinine inclusion!

Well, you'd be almost correct. Looking with a perhaps more critical eye than yours at the ailments listed under "heart," I am forced to agree with you that as far as most of them are concerned, the sufferer had better take himself to bed rather than to the draft physical; and that whoever was responsible for making up the list must have anticipated having to really scrape the bottom of the fitness barrel. Maybe no one made it up. Perhaps it just happened by itself, like most things in the armies of the world.

Let's take a look, anyway.

2-18. Heart.

a. *"All organic valvular disease of the heart, including those improved by surgical procedures."*

Disease or other deformities of the valves in your heart are primarily diagnosed by your doctor by hearing cer-

tain abnormal sounds called murmurs when he listens to your heart. Briefly, and rather unscientifically, murmurs are heard as whooshing, whishing, blowing or other onomatopoeically described sounds, instead of, or superimposed upon, the simple "lub-dup" which issues from the normal heart.

Once upon a time, long long ago, during a distant war which has since become known as The Great War, if you had a "murmur in your heart," you were out. The merest mention of the word and military physicians paled. Quickly, they'd stamp "Reject" on your card, state that you were suffering from "Disorderly Action of the Heart" (DAH), "Da Costa's syndrome" or some other equally vague (and nowadays, purely historically curious) diagnosis, and send you on your way, lest you'd suddenly drop dead and they'd be blamed.

Came another "war to end all wars" latterly listed as Word War, the Second) and all that was changed. No longer did "murmur," "DAH," etc., strike fear in the hearts of physicians. Twenty-five years or so had passed, you will remember, and doctors in the interval had learnt a lot, and were cleverer and more perceptive; or so they thought. Heart murmurs were diagnosed as "functional" (of no significance) as often as not, and many a poor fellow with a severe valvular disease of the heart found himself in the thick of the fray.

Another quarter century rolled by and the "murmur" problem has turned full circle, as the saying goes. But not quite. It has turned, yes, but let us say, on a circle with a different perimeter.

Cardiology has advanced by leaps and bounds over the past couple of decades, and what was fraught with mystery or looked upon merely as a curiosity by our grandfathers, is now subject to all sorts of elaborate tests and graphs and grams and catheterizations, so that it may be truly said that your heart can no longer be looked upon as a safe repository for hidden things. Almost. Murmurs still present their problems, and there is still no certain

method of differentiating "organic" (serious) from "functional" ones.

Some murmurs are quite obviously an indication of disease or other deformity of one of the four valves in your heart. They can be characterized as regards the position on the chest wall over which they are best heard; in what direction they appear to spread (be transmitted); and the time, during the heart-beat, at which we hear them.

Other murmurs, however, are by no means so definitely diagnostic. We hear many "soft" murmurs in children and adolescents, or in adults with anemia or a fever, which disappear as the child grows older or the condition in the adult is rectified. These are generally referred to as "innocent" murmurs, and most doctors can differentiate between them and the ones which result from actual valvular disease. But dab hand though we may be with the stethoscope, there remains quite a proportion of murmurs, the significance of which we are unsure, and experience great difficulty in classifying as "innocent" or pathological. And such problems are almost always posed by gentlemen (and ladies) in your age group.

Of course, we have cardiologists to whom we can refer doubtful cases. If they too, are in doubt about a murmur, they have recourse to phonocardiography and other intricate devices, which are pretty fool-proof diagnostic weapons. Nevertheless, advances in cardiology notwithstanding, like the poor, we will always have in our midst heart murmurs which defy diagnostic classification. Despite every test in the book, they still remain a mystery, and at autopsy some pretty definite entities show up in the heart which were not diagnosed during life.

Such, however, is the stubborn nature of physicians, and of such independent character are we, that many of us will be damned if we can't make up our own minds about such a little thing as a murmur. No cardiologist is needed to help *us*. When, therefore, we are presented with a murmur, the nature of which we are in doubt, we are inclined to rely on old, inexact intuition, and pass our

own judgment. (And that goes for army physicians, too.)

But deep in the hearts of most doctors who are honest with themselves will remain nagging doubts about the correctness of their diagnosis in many cases of heart murmurs. They will hardly express such sentiments to you, but will give you a reassurance that all is well, and that the murmur is purely "functional." I have done so myself. And, after all, most of our time in medical practice is rightly spent in dishing out such reassurances to people, though we may be full of doubts ourselves. Most times, the gamble pays off, and our patients believe us and feel better for it. That's what a lot of the "art and science" of medicine is all about.

Let me assure you, however, that thousands of you with "innocent" murmurs will pose dilemmas for doctors this year. A number of you even, with fairly typical murmurs of valvular heart diseases, will pass the draft physical and be inducted. Doctors, unlike computers, aren't infallible. However, far and away the great majority of murmurs will be correctly classified by the generally competent and conscientious doctors, which, by and large, comprise the medical fraternity in this country today.

If however, you have a heart murmur and you or your doctor still entertain doubts as to its significance, it behooves you both (your doctor especially) to obtain a consultation with a cardiologist.

If I seem to have dwelt too long on this problem of murmurs, it is only because of the healthy respect I have developed in their regard. Perhaps, too, because an old and dear friend of mine was inducted into the service (not of this country) with a condition called mitral stenosis, which remained undiagnosed until after his death in a strenuous military campaign in Germany.

b. "Coronary artery disease or myocardial infarction, old or recent or true angina pectoris at any time."

This connotes cardiac disease of a nature almost unheard of in persons in your age group—except in the case of an extremely rare hereditary disease called “Familial Hypercholesterolemia”—and which precipitated my somewhat caustic comments at the beginning of this section. Why they even bother to mention such a condition beats me. Even the Salvation Army wouldn’t have you!

c. “*Electrocardiographic evidence of major arrhythmias such as . . .*”

This sub-section, together with *d*, and *e*, also deals with serious, or relatively serious, heart diseases, which don’t help us one little bit with your draft problem, except:

c. (1) “*Atrial tachycardia . . .*,” which is synonymous with:

f. “*Paroxysmal tachycardia within the previous five years, or at any time if recurrent or disabling . . .*”

This is a condition in which, on occasions, your heart suddenly takes off like a steam engine. The rate may be so fast that you can’t even count your pulse at the wrist. There is usually a sensation of pounding in the chest and you are stricken with fear. There may be pain of a “crushing” nature in your chest, which may extend into your neck and down the insides of both arms to your finger. Shortness of breath is an almost constant accompaniment. The “attack” may end as abruptly as it began, or it may die down gradually.

This is *not* the usual increase in heart rate which everyone experiences when excited or when undergoing strenuous exertion. It is caused by the heart taking over its own “pacing,” as it were, and ignoring the usual “messages” to speed up or slow down which are sent out from your brain. (Cardiologists stop squirming!)

It is a far from uncommon condition in young people, and is usually found in those of highly nervous tempera-

ment. Attacks are often brought on by "indigestion," or overindulgence in booze, tea, coffee, or cigarettes. It is usually *not* associated with any form of heart disease.

It is obviously a rare event to see a person during an attack, as the bout may only last for a few minutes or up to an hour. It is even rarer to have the opportunity of doing an electrocardiogram while the attack is still in progress. Hence, hundreds of cases must necessarily be diagnosed on the medical history alone, and given treatment, with no electrocardiographic substantiation of the condition. An EKG taken in the interval between attacks is usually normal.

So, here again we have a condition which is diagnosed exclusively (or almost) from the patient's *history* and *subjective symptoms*.

h. "Tachycardia persistent with a resting pulse rate of 100 or more, regardless of cause."

From the above "sublime" heights of "coronary artery disease," we enter the ridiculous realm of the "fast pulse." But it's a boon for you, dear reader, so why should you worry!

Tachycardia simply means a fast heart rate.

The average pulse (heart) rate for adult human beings under resting conditions is 72 beats/minute. This average I have yet to find, though I got close once with a 73!

Many millions of normal people have a pulse rate up in the eighties. Thousands more who have no evidence of disease constantly top the 100 beats per minute mark. If you are one of these (and under conditions of stress like the draft physical, your adrenaline alone will probably give you an extra ten points or so), my heartiest congratulations. Only as a tourist will you ever visit Vietnam!

I don't have to tell you smart ones that the various amphetamine derivatives increase the heart rate as indeed will a couple of cigarettes in quick succession, or strong coffee or booze. However, as mentioned before, the draft doctors are also well aware of this. Remember the "no

smoking or drinking" signs in the draft center waiting-room? And there's no coffee machine either as far as I know.

"Vascular System

b. "*Hypertension* evidenced by preponderant blood pressure readings of 150-mm or more systolic in an individual over 35 years of age or preponderant readings of 140-mm or more systolic in an individual 35 years of age or less. Preponderant diastolic pressure over 90-mm diastolic is cause for rejection at any age."

They're very hot on this blood pressure business, and there are a couple of extra directives which are not included in the present section:

Directive Jan. 24, 1969:

13. "Hypertension.

"a. Individuals with systolic blood pressure readings in the range 136-139, and/or diastolic blood pressure readings of 86-90, with a history of hypertension in the past, should have full documentation of the alleged disorder and/or blood pressure readings in the AM and PM for three consecutive days; either at a government facility or by their private physician.

"b. Examinees found medically disqualified because of borderline hypertension in a three day blood pressure check can be temporarily disqualified with an 'RBJ' in three months to a year. However, if the examinee is found to be hypertensive following two *re-evaluations* he should be permanently disqualified or his records should be forwarded to the Surgeon, HQ, USAREC, for further advice."

And again:

Directive Oct. 15, 1969:

"5. In doing three-day blood pressure readings a preponderance of either normal or abnormal readings is

required to make a final determination. If half are normal and half abnormal, the examinee should be temporarily disqualified.

6. Examinees can only be recalled two times after the initial examination (i.e., for blood pressure, weight, etc.), and if still medically disqualified, should be profiled as a permanent three or four."

The average blood pressure for the human race is 120/80, and contrary to my experience with pulse rates, I do in fact, often find that precise reading among my patients.

Generally speaking—in non-pathological states at least—when your pulse rate rises, so, too, does your blood pressure. And the same artificial stimulants which cause the pulse to race will also serve to raise the blood pressure.

The doctors at the draft physical are sick and tired of blood pressure problems. Wouldn't you, if you were constantly getting "bugged" about it from higher-ups? And should you exceed their listed limits, they will most likely get turned off you. Instead of dragging you back again, they have the option of sending you to your own doctor for repeat readings, and that is what they frequently do. Should he find it still raised, he will so state on the form they give you, which you will then send off and stop worrying about the draft. (Although they do reserve the option to recall you at a later date—see directive.)

Incidentally, and incredibly, you may still be permitted to fly an airplane. The FAA isn't nearly as finicky about blood pressure. You may not be fit for KP, but you can fly a P51!

c. *"Marked circulatory instability as indicated by orthostatic hypotension, persistent tachycardia, severe peripheral vasomotor disturbances and sympatheticotonia."*

The "persistent tachycardia" bit is enough in any case, but let me elucidate. This is that vague no-man's-land 'twixt health and disease, and it's well nigh impossible to describe it accurately. The subject is usually a long thin fellow, who sweats a lot, is as nervous as hell, and has a rapid pulse and a high blood pressure. On occasions he gets very dizzy when he stands up quickly, but he is not impotent and may show a strong flair for painting or other artistic endeavor. He is not athletic, and suffers from bad circulation, and may have pimples and even halitosis. I don't know what to make of him, and neither, evidently, does the army. The draft doctor will most likely look at such an individual, suppress a shudder, and stamp "Neurocirculatory Asthenia" or some other such meaningless diagnosis on his card, and let him go.

If you identify with the above described individual, then you should have no hesitation in making plans for the future which don't include being a soldier.

f. "*Varicose veins*, if more than mild, or if associated with edema, skin ulceration, or residual scars from ulceration."

I won't insult your intelligence by describing varicose veins. Your doctor is the best judge of the "severity" of the condition from the "objective findings" point of view. Only you, though, can give an account of the severity of the "subjective symptoms" they produce. Only *you* have the puffy, swollen ankles in the evening; the aching in your feet, the "charlie horses" and pain in your calf muscles at night. Make the best of them. Varicose veins command respect. They are old and gallant foes of armies everywhere.

SECTION XII.

HEIGHT, WEIGHT, AND BODY BUILD

"God keep lead out of me! I need no more weight than mine own bowel." —*Henry the Fourth; Part I*

One can't elaborate much on the cut-and-dried specifications presented to us in this section.

It is surely superfluous for me to point out that if you happen to be a couple of pounds below the maximum, or above the minimum weight limits, you might take steps to remedy the situation, either by stuffing yourself, or by cutting down on the calories. Nor need the alteration in your avoirdupois be more than of a temporary nature. You can return to your previous state when the danger (the draft physical) has passed. Boxers and jockeys accept this challenge constantly, so why shouldn't you. The stakes, as far as you are concerned, may be your life.

Let's take a look at the listings in this sub-section and see if we can find anything to our advantage.

2-23. Body Build.

c. "*Evidence of congenital asthenia* (slender bones; weak thorax; visceroptosis; severe chronic constipation; or 'drop heart' if marked in degree)."

Without actually presenting you with a living specimen, it is difficult to describe the individual to whom I think they refer in this statement.

It would be easier to illustrate it with a recent case of my own.

Aged nineteen, he was 6' 2" and within the acceptable weight limits for that height (151 lbs.). But he was long and thin and had a sunken chest. He had long gangling arms reaching almost to his knees, and a tendency towards double-jointedness. His head was also long and thin and he had a high, arched palate. He presented an appearance, in effect, of what is commonly described as "a long string of misery," but one could scarcely have submitted such a diagnosis as a cause for military rejection. As described above, he partially fitted the picture of what is known in medical parlance as *Marfan's syndrome*, although lacking the cardiac and other abnormalities usually associated with the full-blown disease. Nevertheless, my diagnosis of "partial Marfan's syndrome" was accepted by the authorities and he was rejected. Rightly so, in my opinion, as he couldn't conceivably have withstood the rigors of military training, let alone grappled with the Viet Cong.

I quite realize that no one with an ounce of pride will admit to fitting this picture. I would refer you, therefore, to that cri-de-cœur of the poet, Robert Burns, who wrote: "Oh wad some power the giftie gie us, to see ourselves as others see us."

An old friend may look at you with more detachment than you yourself can, and your doctor will be blunt, though kind. Pocket your pride, therefore, and accept the opinion of others.

d. "*Obesity*. Even though the individual's weight is within the maximum shown in table I or II, as appropriate, appendix III, he will be reported as medically unacceptable when the medical examiner considers that the individual's weight in relation to the bony structure and musculature, constitutes obesity of such a degree as to interfere with the satisfactory completion of prescribed training."

There is a specific medical entity entitled "*Fröhlich's syndrome*," for an example of which medical authors almost invariably refer you to the Fat Boy in the "Pickwick Papers." The complete syndrome, which is caused by some defect in the hypothalamus (a gland up in your brain near the pituitary), presents a roly-poly individual, who stuffs himself continually with food, and has underdeveloped genitals. He finds it difficult to stir himself, tires easily, and falls asleep at the drop of a hat.

You don't have to be a facsimile of Mr. Dicken's character in order to be draft rejectable. You may tend in that direction, however, from a partially deficient hypothalamus, and your doctor could present quite a strong case on your behalf. To back up his diagnosis, you might even fall asleep during the draft physical!

SECTION XIII.

LUNGS AND CHEST WALL

"Each man is born to one possession which outvalues all the others—his last breath."

—Mark Twain, *Following the Equator*

With one or two exceptions, the pathological conditions listed here are serious diseases or complications resulting from them. There is nothing "borderline" about most of them, and if you are now, or ever have been, afflicted with such ailments, then you won't need to read this book. You will have known for ages that the army wouldn't have you in a fit.

The rest of you take heart, however. The list contains a couple of lovely little diseases, which, though they may render you breathless on occasions—gasping even—are to be preferred to having shrapnel in your lungs.

2-24. General.

a. "Abnormal elevation of the diaphragm on either side."

This is purely an X-ray finding. The causes are legion, some trivial, some serious; but in any event, of no concern to us here.

e. "Acute mycotic disease of the lung such as coccidioidomycosis and histoplasmosis."

This must be taken in conjunction with:

2-26. i. "*Chronic mycotic diseases* of the lung including coccidioidomycosis; residual cavitation or more than a few small sized inactive and stable residual nodules demonstrated to be due to mycotic disease."

I include this entity mainly out of sentiment for California, for, from one of its mountain-ringed valleys, one of the above diseases derives its name.

San Joaquin Valley fever (coccidioidomycosis) is an acute illness caused by a type of fungus. People of any age are susceptible, but it is found mainly in males. You contract it either from rodents or the soil, but not from another human being. The acute disease is like a bad bout of the flu. You have fever, sweats, chills, and a cough from the bronchitis it usually produces. You could also develop a rash on your legs or elsewhere, and the glands all over your body are often swollen and painful.

The vast majority of cases clear up in a few weeks, even without treatment. A percentage, however, never quite get rid of it, and the disease progresses to the chronic stage.

This stage is characterized by a shadow, or shadows on your lungs, which is often confused with TB even by expert radiologists. The shadows are called granulomas, and it is sometimes impossible to tell whether such a "lump" represents old, healed disease, or is still "active" (still full of fungi ready to sally forth and do battle with you again).

Such was the case in a recent patient of my own. Rack my brains and his body though I would, I couldn't find a thing the matter which might exclude him from the draft. I was at my wits' end until he happened to mention that he had been stricken with "Valley" fever a few years previously. A subsequent X-ray of his chest revealed the typical granuloma, and I quote directly from the radiologist's report which was responsible for eliminating him from the draft: "There is an area of opacity in the right

mid zone which has the appearance of a granuloma. The lesion is localized and appears to be quiescent. In the absence of old films for comparison, however, *it is impossible to state this with certainty.* (My italics.) Repeat chest film after an interval is recommended."

When the draft people saw this, they turned him down. They could, of course, have given him a deferment and reviewed the case after three months. Luckily for him however, they didn't seem to want to be bothered.

h. "Foreign body of the chest wall causing symptoms."

If you were ever lucky enough to get shot in the chest and weren't killed, and the bullet lodged in the muscles, and you are reluctant to have it removed; and if it pains the hell out of you, especially when there's a change in the weather, you're OK. You won't be exposed to such violence again. Not in war anyway.

i. "Lobectomy, . . . removal of more than one lobe is cause for rejection regardless . . ."

One lung and they leave you alone. But one ball and you're in, remember. Don't worry, however. It will never be up to you to decide which to sacrifice!

1. "Recent fracture of ribs, sternum, clavicle or scapula."

You get a temporary "out" in this instance. But only for three months. And if I were you, I'd forget about that fractured collar bone as a means of achieving what you really want.

m. "Significant abnormal findings on physical examination of the chest."

There are a few conditions in this context which are more or less congenital abnormalities of the chest wall, and which, depending on the whim of the draft examiner, and/or the vehemence of the letter from your doctor, could be cause for rejection. They are: *Pigeon chest*, *funnel chest* (pectus excavatus), and *Harrison's sulcus*.

Pigeon chest, as the name suggests, is a condition in which the sternum (breast bone) bulges forward inordinately, especially at its lower end. Funnel chest is again self explanatory, and is a condition in which the normal "hollow" at the bottom of the breast bone is grossly exaggerated. Harrison's sulcus is a depression of the ribs extending as a groove across the lower part of the front of the chest.

None of the above conditions is necessarily associated with any abnormality of the lungs. The degree of deformity will vary with each case, of course, and only your doctor can give you an estimate of how "bad" it is, and how it might affect your chances for induction.

There are really no grounds for controversy here. The stipulations speak for themselves and I have nothing to add.

2-25. "Tuberculous Lesions."

2-26. "Nontuberculosis lesions."

b. "*Bronchial asthma*, except for childhood asthma with a trustworthy history of freedom from symptoms since the 12th birthday."

With the first listing (2-25) there are really no grounds for controversy. The stipulations speak for themselves and I have nothing to add.

On nontuberculous lesions we can say (with apologies to Churchill) that rarely in the field of draft evasion was so much owed by so many to this lone disease. Once again a delightful incapacity from our standpoint. A subtle little thing. The army, too, is well aware of this, and it has been the subject of many extra medical directives:

Directive of January 24, 1969:

2. Asthma and Respiratory Diseases.

a. Medical officers are reminded that according to para 2-26b, AR 40-501, individuals with a history of bronchial asthma since their twelfth birthday are medically disqualified. Applicants with documented asthma up to fifteen years with subsequent freedom of symptoms will be considered for waiver by the Surgeon, USAREC.

b. The terms asthma, asthmatic bronchitis and bronchial asthma, are considered synonymous for purposes of medical qualifications.

d. A number of EPTS (existing prior to service) discharges for asthma have come to the attention of this headquarters. *Asthma was noted and documented at AFEES* (my italics), but since no treatment with either steroids or adrenaline had been given, the examinee was found qualified. It should be noted that many private physicians treat mild asthma without these two drugs. Therefore, the lack of treatment with steroids or adrenaline is not valid evidence for discounting the diagnosis of bronchial asthma."

This isn't like the army; making it so easy, I mean. Heads must have rolled on occasions over asthma. Senators must have been annoyed and written letters. Or perhaps Hershey had it as a boy. No matter. Ours is not to reason why.

Bronchial asthma can be caused by a variety of factors, and attacks can be precipitated by any one of these or any combination of them. The causes include: allergy, infection, psychosomatic tendency, mental or physical stress, and there is commonly a family history of the disease.

The disease usually commences in childhood and there is a tendency for the attacks to lessen in frequency and severity as the 'teens roll by. Such, however, is certainly not invariable, and thousands of erstwhile child asthmatics repeatedly wend their wheezy way to the doctor's

office (or call him out at night) when the bloom of their youth has long since departed. In many cases they do this during the whole course of their lives.

What is this asthma? The essential and immediate cause is a temporary narrowing of the bronchial tubes, way down in the substance of your lung, through which the air must pass on its way to the final little "cells," where it gives up its oxygen to the blood stream and collects the "garbage" carbon dioxide, which is then gotten rid of when you exhale—further polluting our environment.

This narrowing of the bronchi interferes with your ability to suck air into your lungs, but it has an even greater effect on your capacity to push the impure air out again. (Physiologically, in case you didn't know, you are better equipped—have more things "going for you"—for taking in a breath than for letting it out.) If infection plays a part in your particular attack, then the narrowed bronchial passages are further narrowed by all sorts of phlegm, mucous and stuff, and your distress is further aggravated.

The treatment will vary with the severity of the attack. It could include: antibiotics for the infection; anti-histamines, if it is mainly due to allergy; sedatives if you're all nervous and panicky; most importantly, drugs which relax the muscles in the walls of the clogged-up tubes and open them up. Such medications include, *inter alia*, adrenaline and its various analogues, aminophylline and kindred pharmacological souls, and in severe, life-threatening cases, steroids (cortisone). Oxygen, of course, is often a virtual life-saver.

In the interval between attacks it is often necessary to keep the patient on constant doses of one or other of the drugs listed above, both in order to prevent subsequent attacks and sometimes, in long-standing cases especially, as a necessarily constant aid to respiration.

How is it diagnosed? During an established attack there's not much doubt about the diagnosis. You are sitting up, gasping for breath, and probably pouring with perspiration. The doctor hardly needs a stethoscope to

hear your wheezing, but when he does listen to your chest, he is rewarded by all sorts of lovely little musical piping sounds as you strive for air. Especially when you attempt to breathe out does the orchestra really strike up. In his unromantic scientific nomenclature, prolongation of expiration is what the doctor calls this.

Then he treats you by giving you the requisite shots—probably intravenous aminophylline or subcutaneous adrenaline—with tablets to follow, or puts you straight into a hospital if you're bad enough. Then, before long, the attack passes, and you're better. Illness is a thing of the past, and you're feeling yourself again. Until next time.

Draft-important points: (1) Between attacks you feel great, and there's not a wheeze to be heard in your chest when the doctor examines you (unless you have progressed to the chronic stage when there'll always be a wheeze or two around).

(2) Many, whose childhood attacks were severe enough to warrant medical attention learn how to "cope" with their attacks themselves as time goes on—the attacks will probably now be less severe—and don't bother to see a doctor.

(3) Chest X-ray reveals nothing abnormal, except in long-standing cases, when signs of emphysema may become evident (see below). Even at the height of the attack in a young person, the X-ray would be expected to be normal.

(4) It is important to pay a visit to your doctor during an attack, however mild, so as to have the episode officially recorded for future "use."

The diagnosis of bronchial asthma, therefore, frequently rests solely on the history given by you, the patient, and on your description of your "subjective symptoms." There may rarely be an occasion during the long course of your malady when a single positive "objective finding" is noted.

And thereby hangs a tale!

' c. "*Bronchitis, chronic with evidence of pulmonary function disturbance.*"

Chronic bronchitis and its common accompaniment emphysema (see below), though unusual in people in your age group, is certainly not unknown. The "chronic" variety invariably follows repeated attacks of acute bronchitis, "a chest cold," which often ensues as a complication of a "head cold" or other upper respiratory infection.

The condition differs from asthma in that infection is the main, or only, cause. There is never the same difficulty with expiration, though you may be pretty breathless a lot of the time. The cough too, is different, and especially in the acute type, you cough up thick yellow phlegm, which would be unusual in uncomplicated bronchial asthma.

As the chronic stage supervenes, you have a more or less constant cough, especially in the mornings, with the production of varying amounts of phlegm. Cigarette smoking (or living in Los Angeles!) makes the condition worse, and some "pot" smokers have been forced to give up their habit because of attacks of acute bronchitis resulting from as little as one or two "hits."

f. "*Bullous or generalized pulmonary emphysema.*"

Emphysema is primarily an X-ray (or autopsy) diagnosis. The lungs appear larger and fuller, and, paradoxically, "clearer." Clinically, it is marked by a "stiffness" of the chest wall, with restricted movements when you breathe. The normal respiratory excursion (the difference in diameter of your chest as measured with a tape when you take in a deep breath and then let it out fully) of 2 inches or more is restricted, and depending on the severity of the condition, may sometimes be less than one inch.

At your age, you're very unlikely to be affected to this degree. If you are, however, think more in terms of filling out your will than draft questionnaires!

SECTION XIV.

MOUTH, NOSE, PHARYNX, TRACHEA,
ESOPHAGUS, AND LARYNX.

"Those who in quarrels interpose
Must often wipe a bloody nose."

—John Gay: *The Mastiffs*.

2-28. "Nose.

a. *"Allergic manifestations.*

(2). "Hay fever if severe; and if not controllable by antihistamines, or by desensitization, or both."

Hay fever is a misnomer as it has little to do with hay, in which you may still romp with impunity whether you have it or not. Its medical name is allergic rhinitis, and there can hardly be a man, woman or child in the United States who hasn't heard of the condition. How could you miss it, what with the present fad for allergies in general, and the forceful way in which remedies for such conditions are thrust at us on television.

Anything on the face of the earth to which you happen to be allergic can theoretically cause "hay fever," though in the present context, the common lay concept that plants and pollens are the main offenders is by and large acceptable.

Sufferers from the condition could undoubtedly add to the following list of symptoms. However, I hope that it will give you lucky ones a rough idea of what you're missing.

There you are, minding your own business, taking a

carefree stroll in the country on a nice spring day. Suddenly you get a tingling sensation in your nose, and your eyes smart. Soon you are sneezing like mad, and your eyes stream with tears, and you feel generally "bunged up" and unwell. Then, if the frequently concomitant allergic asthma also strikes, you wheeze like an old bellows and get into one hell of a state.

Quickly, you remove yourself from the vicinity of the offending weed, and hurry home to your nasal sprays and antihistamines. If you're lucky, and haven't retained any of the noxious stuff on your clothing and your back-yard isn't full of a similar vegetable, the symptoms soon abate with the aid of your household remedies. Your puffy eyes subside and your nose stops dripping.

Most hay fever sufferers don't get of that lightly, however. The ubiquitous pollen hangs on the air and pursues them constantly, and for the whole of the mating season of their particular flower, they sneeze and sniff and itch, and have a rotten time in general.

Then perhaps another plant begins its orgy, and they're allergic to that too. For a further month or more they're similarly affected. Some, in fact, are so allergic to so many plants and weeds and flowers and grass and things, that they rarely get respite during the whole course of the year.

Antihistamines are dished out by the ton at certain seasons—spring and early summer mainly. They work well enough, or at least serve to lessen the condition. But they can also make you sleepy, and too frequent usage may result in a weakening of their efficacy.

Then we enlist the aid of the allergist, who tests your skin and determines which particular plant or object is causing your trouble. He then concocts a special solution containing a weak strain of your "poison." He tries to "desensitize" you by giving you regular injections of gradually increasing doses of the stuff. The object is that as the years and your money roll away, you will gradually become accustomed to your enemy, so that you can both live in happy symbiosis with each other forever

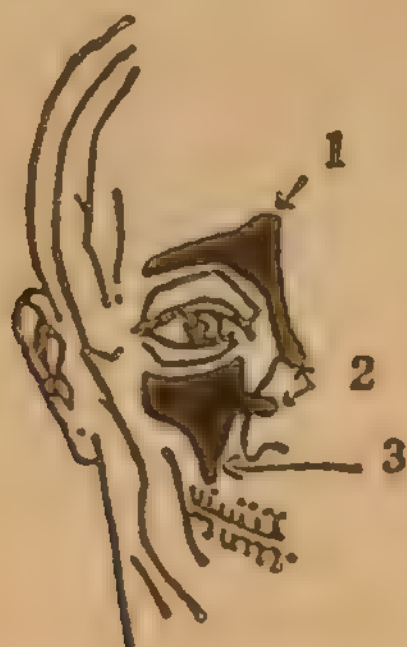
after. (And at the risk of incurring the eternal wrath of allergists everywhere, I must state that, in my opinion, it's all a load of codswallop. I have yet to see a case which benefited more than mildly—psychologically perhaps—from such shenanigans.)

Thus we arrive at steroids (cortisone). This stuff isn't candy and has to be used with caution. It is, nonetheless, a most useful weapon in our anti-hay fever armamentarium, and is frequently effective when other measures fail. There is a preparation of cortisone available, which, given by intramuscular injection, acts as a sort of reservoir of the drug in your body, and can keep patients free of symptoms for anything up to a month. Patients swear by it, of course, and doctors (warily) find it very useful.

What about you and the draft? If you suffer from hay fever of sufficient severity that it cannot be controlled by antihistamines—and only you can tell whether they help you or not—and your doctor is forced, even if only occasionally, to resort to cortisone to alleviate your malady, then, according to the regulations, you are ineligible for the draft. However, you must stick to your rights, and let people know. The meek, in spite of suggestions to the contrary, inherit very little.

e. "*Sinusitis, chronic*, when more than mild:

(1) "Evidenced by any of the following: Chronic



1. Frontal sinus
2. Openings of sinuses into nasal cavity
3. Maxillary sinus

purulent nasal discharge, large nasal polyps, hyperplastic changes of the nasal tissues, or symptoms requiring frequent medical attention."

For practical purposes, and simplicity, you have two sinuses on each side of your face (see diagram). Sinus is really a misnomer, as what is actually meant in this context is rather an "air space" in the bone of your skull from which tracks, or "sinuses" open into your nose. Sinusitis, as the word is generally used, means an inflammation of, with possibly a collection of pus in, these air spaces.

Sinusitis is caused almost invariably by a "cold," during the course of which germs find their way along the passages and set up infection in the sinuses.

Inadequately treated—or if free drainage into the nasal cavity is impeded either by some anatomical abnormality of the sinus opening, or because the nose continues to be "bunged up" or whatever—the sinusitis may become chronic and recurrent.

Symptoms can be quite severe and consist of pain over the site of the offending sinus. The pain may radiate all over the place: into our teeth, ears, eyes, etc. It's no joke, and often needs narcotics for relief. Antibiotics and nasal decongestants are usually effective in controlling the acute attack. They serve little to prevent recurrences, however, should chronic sinusitis ensue and the infection take a firm hold. In some resistant cases, surgical drainage of the sinus has to be undertaken by an ENT specialist. Chronic sinusitis therefore, can be a painful, extremely uncomfortable, and often quite disabling condition.

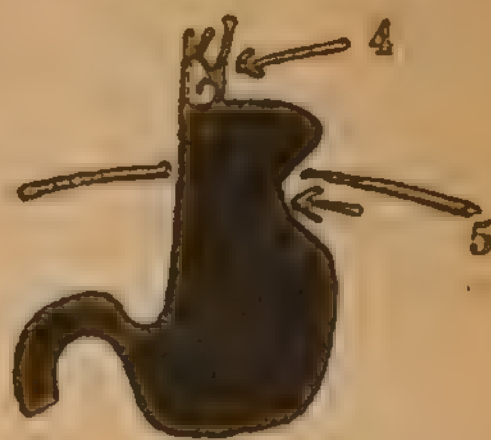
No cloud, however, is without its silver lining. Plague your doctor with each attack. If you make his life, too, a misery, he'll be sure to write and warn them at the draft not to accept you under any circumstances!

2-29. a. "*Esophagus*, organic disease of . . . peptic esophagitis: if confirmed by appropriate X-ray or esophagoscopic examinations."

A very common finding on X-ray examination of the stomach is a condition called a hiatus hernia. (See diagram.) It is found in quite a large proportion of persons (even at your age) who have no symptoms pertain-



Normal



Hiatus Hernia

1. Esophagus (Gullet)
2. Diaphragm
3. Stomach
4. Site of peptic esophagitis
5. "Hole" in diaphragm is too large, so that a portion of the stomach can slip above it.

ing to that condition and who are X-rayed for some other reason. Peptic esophagitis simply means an inflammation of the wall of the lower esophagus, by gastric (stomach) juices, which, because of the hernia, can leak up out of the stomach.

Symptoms of peptic esophagitis include: a burning, nauseating feeling behind the lower sternum, occurring typically when you lie down or stoop forward. Like in the case of duodenal ulcer, it is relieved by milk, antacids, etc., and in this particular instance, by assumption of an upright position. Indeed, many sufferers are forced to adopt a semi-vertical posture, with the aid of extra pillows, even while they sleep.

I think it important enough to repeat at this point, as I mentioned in the section on the "stomach," that should you have any symptoms of indigestion, however slight, and no matter how unimportant you might consider them, you should go to your doctor and ask his advice regarding a barium meal examination. Even if they only

find a hiatus hernia, this alone, plus your symptoms, equals peptic esophagitis, and you can't be drafted.

2-30. a. "*Aphona*."

Well, what do you know! If you can't talk they don't want you! You'd better start practicing "playing dumb" early on in life, however, to stand any chance of simulating this condition at your draft physical.

SECTION XV. NEUROLOGICAL DISORDERS

"Indeed, I tremble for my country when I reflect that God is just."

—Patrick Henry, 1775

Except for one outstanding "dandy" of a disease, my efforts to extract blood from this barren list of turnips has been fraught with frustration.

If you've ever suffered from a stroke, you're in fine shape; or have paraplegia and drive a wheelchair; or suffer from epileptic siezures and think that you're Napoleon! The majority of you though, who merely get a bit shaky after a night on the booze, or once had a slight brain hemorrhage from which you recovered, I can't help much.

Take sub-section *a*, for instance. Not only are these all rare conditions, they are also of such an obviously serious nature—in many cases, fatal—that I am at a loss to understand why anyone even bothered to mention them. Most of the unfortunate victims suffer also from severe mental symptoms, to the point that many have to be confined to mental institutions. Perhaps the list has been included here by mistake. Maybe it indicates the standards required in order to be a general!

b. "Miscellaneous.

(2) *Migraine*, when frequent and incapacitating."

Here's the "goody" I promised you.

Migraine, as you are all well aware, derives its name from the two Greek words, hemi- (half), and kranion (your nut). This implies that the headache which is the characteristic of this condition is confined to one side of your head. And such is nearly always the case.

The disease runs in families, and the victims are almost invariably highly intelligent, introspective, meticulously responsible, and highly sensitive nervous people—footballers, push on to the next section. If you watch TV a lot—apart from getting migraine—you will have noticed that sensitive people like that hate like hell having to draft young fellows and send them off to war. They get so upset about it, and get such a headache, that they must first retire to the lavatory and take a "Bufferin" tablet before returning to carry out the foul deed.

Most migraine sufferers have a fair idea when an attack is about to commence. Their mood may change and they frequently experience a peculiar sense of well-being. Alternatively, they may become very depressed. The eyes are often affected first. The subject sees all sorts of colored lights (which aren't there); or spots or squiggly lines; or there may be partial or complete loss of vision. Soon the blood begins to pound into one side of your face and head. Throb . . . throb . . . throb it goes, until you think that your skull is about to burst. Most likely, you also experience a sense of nausea, and may vomit. You can't tolerate any sort of light, so you crawl into the darkest corner you can find, and lie down and suffer in silence.

The duration of the attack varies. It may finish in an hour or last for days. This depends, of course, to a large extent on whether or not medication is taken, the circumstances which precipitated the attack in the first place, and all sorts of other variables; in women, the time of the month is also relevant.

We doctors try a host of remedies and medications, the very multiplicity of which suggests that no one thing is of much benefit. Reassurance and a modicum of sympa-

thy, the textbooks tell us, are useful means of treatment. In my opinion these factors transcend the vast majority of pills and other things we use. Some form of ergot preparation has a hallowed place in the treatment of migraine and can be given by mouth, by injection, as a suppository, or even by inhalation. In my own experience, these are about as much use as a hole in the head in most cases of migraine. (And before you "ergot-for-migraine" apostles start shouting off your mouths at me, I would suggest that I am as much entitled to my opinions and conclusions as you are!)

Aspirin is used, and the various combinations of this with other drugs; also, sedatives, tranquilizers, anti-nauseants and whathaveyou. Occasionally these remedies work, but some attacks of migraine of more than average severity can only be relieved by an injection of an opiate or other form of "narcotic."

The frequency with which the headaches occur is again very variable, although the attacks are likely to be fairly evenly spaced for any particular individual. As long as a year may elapse between attacks, or they may recur weekly. Psychosomatic precipitating factors loom large here. If your wife's mother arrives every other Saturday, and you hate her guts, then you'll most likely get your migraine every fortnight (or until you get rid of your mother-in-law, or your present wife).

There are no specific tests for migraine. Oh, you can (and should) undergo all sorts of neurological tests, and have spinal taps and EEG's and skull X-rays etc. These will serve to rule out some other serious condition of the brain or elsewhere as a cause for your migraine. In the vast majority of cases, however, all these tests are negative. By a process of exclusion, therefore, we classify you as having just migraine. (As if you didn't already know!)

Do *you* suffer from migraine which is "frequent and incapacitating"? Only you know the answer. Only from your symptoms can I (or any other doctor) diagnose your malady. Should we even examine you at the height of your attack, we have no means of telling—apart from

your agonized expression and the ice-packs around your head. There are no "objective findings." (Lest purists take me to task in this regard, I hasten to add that the arteries and veins around that part of your head *may* be dilated more than normal. However, I have yet to observe this.)

As usual, though, from the draft point of view, it would be useful to have a few of your incapacitating attacks medically documented . . . *in advance* of the draft physical.

(4). "Tremors, . . . more than mild."

Tremor means a regular involuntary shaking of the hands and fingers; maybe also of the tongue and lips and other parts of your body. The emotional trembling we all experience on occasions isn't meant in this instance, nor the, "she was tremulous with excited anticipation" you read about in certain kinds of novel.

Tremor can be caused by disease. In your age group the most likely pathological tremor would be part of the symptoms of an overactive thyroid; or the result of drinking mercury in large quantities, if you have such a habit. Far and away the commonest tremor of medical import which at your tender age you might experience, is known as hysterical tremor. By hysterical isn't meant that you have to "throw a fit" to get it; or witness some gruesome murder. There are thousands of well documented cases of hysterical tremors in nervous individuals, which are constant, and which certainly interfere with the health and well-being of the possessor, and are undoubtedly "more than mild."

SECTION XVI.

PSYCHOSES, PSYCHONEUROSES, AND PERSONALITY DISORDERS

“For if he like a madman lived
At least he like a wise one died.”

—Cervantes, *Don Quixote*.

There have always been “gray” areas in medicine—in life too, for that matter—where it is difficult to draw a dividing line between what is normal and what should be considered abnormal. In no branch of medicine is this more evident than in psychiatry. It would be impossible in a work of this nature to delve too deeply into such an abstruse subject, nor would it serve much purpose. Besides, I am not an expert psychiatrist.

It is for such a specialist to pronounce on your suitability for the draft should you suffer from certain of the conditions listed in this section. These include the psychoses, and only a psychiatrist is equipped to evaluate them.

In the actual day-to-day practice of medicine however, the vast majority of illnesses labeled “psychiatric” are dealt with by non-specialists. Even the army (see directive below) considers that many induction candidates with psychiatric histories can be adequately dealt with by army doctors without special psychiatric training. It is on this general premise, therefore, that I presume to discuss certain conditions I have chosen as being most applicable to our present purpose.

This is a “gray” area for the military authorities too,

and one which they tread with extreme caution, and for very good reason.

At Fort Dix, New Jersey, and nearby McGuire Air Force Base there were 96 attempted suicides among 37,000 trainees in the second six months of 1968. There were nine actual suicides, and six of the nine were trainees. And of course, all of these men had been passed as psychiatrically fit for service at their pre-induction physicals, two of them in the preceeding twenty-four hours!

So, the authorities have become rightly concerned. This is evidenced by the issuance of the following directives (not available in Appendix C).

Directive of Jan. 24, 1969:

22. Psychiatry.

a. *More credence should be given to diagnoses made under private physicians, especially in the area of psychiatry* (my italics). If evidence is submitted which is disqualifying, then disqualify.

b. AFEEES Medical Officers are permitted to function as psychiatric examiners when the services of a psychiatrist are not available within a period of two days. However, in cases of Congressional or Presidential interest or in security cases on which a psychiatric evaluation is necessary, then the services of a qualified psychiatrist must be obtained regardless of the time elements involved.

Directive of July 22, 1969:

1. Examinees undergoing active psychotherapy should be temporarily disqualified if improvement is expected, or permanently disqualified if no improvement is expected.

2-32. Psychoses.

These are the mad one, the schizophrenics and manic-

depressives, etc. This is the exclusive province of the psychiatrist.

2-33. Psychoneuroses.

Included here are the "minor" psychiatric upsets, such as mild degrees of depression, anxiety states and so on, with which every doctor is confronted daily.

Having carefully perused their list, I must conclude that herein could conceivably be included every little emotional upset under the sun. The catalog would be limited only by your own, or your medical adviser's, imagination and/or philosophical interpretation. Let's read precisely what they say:

a. "History of a psychoneurotic reaction which caused—

(1) Hospitalization

(2) Prolonged care by a physician.

(3) Loss of time from normal pursuits for repeated periods even if of brief duration.

(4) Symptoms or behavior of a repeated nature which impaired school or work efficiency."

With this, let us include:

b. "History of a brief psychoneurotic reaction or nervous disturbance within the preceeding 12 months which was sufficiently severe to require medical attention or absence from work or school for a brief period (maximum of 7 days)."

I—and every other doctor in the country too, I'll wager—constantly see people of all ages, who are suffering from their "nerves," or "who can't take much more," etc. These people are far from being mad or psychoneurotic or otherwise abnormal, but such are the harsh exigencies of present day living that they are forced to take refuge from the "rat race." The doctor's office—which, rightly or wrongly, has come to replace the confessional

or the confidential chat with the minister—is that haven. There they flock daily in thousands: the unhappy housewives; office workers; artisans of every description; students in droves, etc. All sorts and conditions of people, and in every age group—yours included.

And what do we do? We have to do something for them. For the rich we prescribe a vacation or a cruise, and enter “exhaustion” or some equally vague diagnosis in his notes. None of my patients is rich, however, and should I feel disposed to grant him a brief respite from his daily toil, I must perforce give him some written “excuse” for his employer.

No Fifth Amendment do I plead. As often as not I state that they have the flu or some other minor ailment and everyone is happy. Why do I have to lie? Well, it appears that a diagnosis of “acute anxiety state” or an “attack of nerves” or anything even remotely connoting an emotional or psychiatric instability might have dire consequences as far as the jobs of the majority of people are concerned. I don’t know why, but such seems to be the case.

Nor is the need for a “rest” confined to adults. School children in all grades present themselves to us, looking for excuses for this or that. Patently behind the timorously presented medical or surgical “complaint” is the obvious, common need to “get away from it all.” The older grades, particularly university students, constitute an inordinately large proportion of such petitioners.

So there you have it. Much depends in this instance on your doctor. If he considers that your “illnesses” during the year, because of which you were “absent from work or school for a brief period,” should be classified as psychoneurotic, and he is prepared to state as much in his letter on your behalf to the draft, then, as I interpret the regulations, they have no option but to turn you down.

2-34. Personality disorders.

a. *Character and behavior disorders*, as evidenced by—

(1) "Frequent encounters with law enforcement agencies . . . an impaired characterological capacity to adapt to the military service."

Your friendly lawyer is in a better position than I to advise you as to how "bad," or how much of a "criminal" you need to be to fit this category.

Incidentally, where in heaven's name did they dig up "characterological"!

O tempora! O mores! Oh, what is being done to the English language!

(3) "Chronic alcoholism or alcohol addiction."

Here I would like for a moment to indulge in a bit of speculation. Supposing that there was this young fellow of, say, twenty-two, who has been attending Alcoholics Anonymous meetings for one, two, or three years. He is a self-confessed alcoholic and has ample evidence before joining AA to support his claim. He is an alcoholic, and yet he hasn't had a drink in a couple of years and is holding down a steady job. Alcoholism, we know, is a life-long disease—the AMA said as much last year. In spite of his long abstinence, our man is still a victim of "alcohol addiction." Is such a man draftable? Maybe the Supreme Court could decide—if it doesn't go out of existence first!

(4) "Drug addiction."

Do you confess your addiction and get sent to jail? Or do you conceal it and end up in Vietnam? Yours is the choice, Hobson's though it be.

c. "Other symptomatic immaturity reactions such as authenticated evidence of enuresis which is habitual or persistent, not due to an organic condition (para 2-15c) occurring beyond early adolescence (age 12 to 14) . . ."

Enuresis = bedwetting.

This is only a story.

You go to your doctor and complain that you have been wetting the bed frequently for ages, but never had the nerve to mention it until now. He probably gives you a superficial examination and tests your urine. Then it's likely that he will put you on some kind of pills and will offer the advice to curtail your fluids in the evening and to eliminate coffee, tea and alcohol from your list of beverages. Off you go. You are back a week later with the tale that there has been absolutely no improvement, and your mother/landlady is furious. He may try you on a different type of pill, but more likely will refer you to a urologist.

This specialist examines you more carefully, and takes some blood and urine samples, and sends you for an X-ray of your kidneys (IVP—intravenous pyelogram). All the tests come back negative of course. This fact the urologist will communicate in writing to your doctor, and wash his hands of you.

Back you go to your doctor, who tells you to go to hell and find another doctor, or if his patience hasn't yet given out, explains that your little problem may have some deep-seated psychological meaning which eludes him, and that maybe you had better see a psychiatrist.

The psychiatrist delves deeply into your masturbation habits and inquires if your mother enters into your sexual fantasies. By the time he has finished with you, you may have the definite impression that you really *are* "nuts." He may or may not prescribe a tranquilizer, but tells you not to worry in any case, and that he is returning you to the care of your family doctor.

You don't dare to visit that poor man again of course, and give up your dishonest peregrination. When the time for your induction physical is at hand, however, you politely request copies of the voluminous correspondence on your interesting case. Then, if you are able to transport them all to the draft center, not only will they turn you down, but they may even feel so sad about you as to throw in a stack of Blue-Chip stamps for your new sheets!

SECTION XVII. SKIN AND CELLULAR TISSUES

"An' all for 'is dirty hide, 'E was white, clear white inside."

—Rudyard Kipling, *Gunga Din*

Most of the conditions listed under this section will have been evident for a long time, and the chances are that you will already have been treated by a dermatologist or other specialist.

Many are serious and disabling conditions which will most certainly exclude you from the draft. Some, though, are rather borderline and I have limited my comments to these.

a. "*Acne*. Severe, when the face is markedly disfigured, or when extensive involvement of the neck, shoulders, chest or back would be aggravated by or interfere with the wearing of military equipment."

The above is really self-explanatory. "Extensive involvement," however, may be variously interpreted both in the mind of the medical examiner and in that of the sufferer. And *you* are the sufferer!

One point: Acne is often only kept at bay by the administration of antibiotics, either in intermittent courses or continuous small doses. If yours is such a case, make sure that the draft medical examiner knows about it. You will hardly be inducted if it requires constant antibiotics

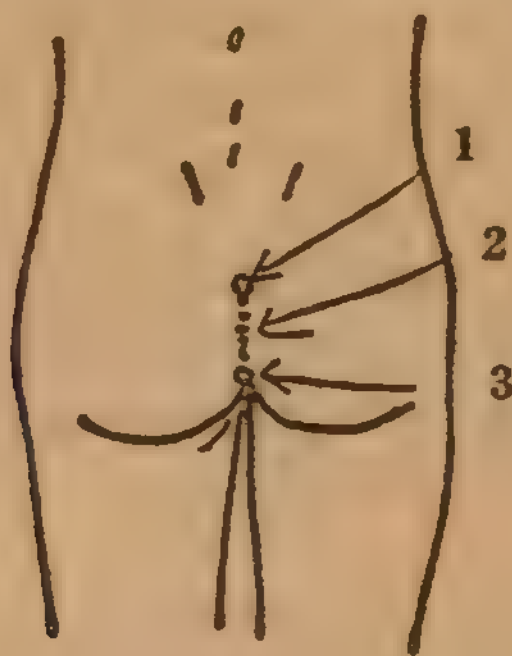
to enable you to hike a pack around on your back in the jungles of Vietnam!

c. "Cysts.

(1) *Cysts, other than pilonidal.* Of such a size or location as to interfere with the normal wearing of military equipment."

The ideal condition would be a lump (sebaceous cyst, lipoma, etc.) in the region of the shoulder or the upper back, where it might be impinged upon by shoulder straps and other military harness. The inconvenience to your comfort would of course be "subjective," but the cyst would have to be pretty large to give you an "out." If you have one, though, don't have it removed until after the draft!

(2) "*Cysts, pilonidal.* Pilonidal cysts, if evidenced by the presence of a tumor mass or a discharging sinus."



1. Pilonidal cyst
2. Track under skin
3. Sinus opening

Pilonidal cysts are fairly common developmental abnormalities and are found especially in hairy individuals. The probable cause is a hair, or hairs, which become trapped between joining layers of skin down near the

tail-bone in the cleft between the cheeks of your buttocks. (See diagram.)

The buried hair forms a little protective "bag" or cyst around it. Occasionally the cyst becomes infected, with the formation of pus, which "tracks" along under the skin for some distance before reaching the surface through a little hole called a sinus. If the infection becomes chronic (permanent), this sinus persists as a means for the pus to escape with each succeeding flare-up of the cyst. Antibiotics result in a temporary "cure," but the condition is almost certain to keep on recurring unless it is surgically removed. It is a troublesome ailment and grounds for draft rejection. You could, of course, delay the surgery until you are an old, old man!

d. "Dermatitis factitia"

Loosely translated this means any self inflicted disease of the skin. It includes the application of chemical irritants, burning oneself, causing ulcers of the leg and other areas by the tight application of coins, etc. There are hundreds of examples, limited only by the ingenuity of the perpetrator. Unless a physician is very alert he may fail to diagnose the "disease."

Most of the above examples are part and parcel of a neurotic or psychoneurotic illness. The occasional "normal," non-hysterical subject who resorts to such tactics in order to evade anything (the draft included) has no place in my sympathies. This is fraud, purely and simply, and it serves him right if he is discovered by the army skin specialist, as he almost certainly will be. This is not "playing fair," and I mention such subterfuges merely to condemn them.

There is one form of "dermatitis factitia" however, which does not draw my wrath, and which must be sympathetically explained. I refer to the scratching to which patients with certain skin lesions of an itchy nature are forced to resort to. Many mild "allergic" and other skin ailments may cause pruritus (itching), but in many cases

the skin may be apparently normal. The "attacks" of itching may be brought on by exposure to the sun, the wearing of certain types of fabrics next to the skin, or the innocent application of many types of perfumes, deodorants, etc. However, in many cases no cause can be found.

Under such circumstances you are *not* a malingerer. Even though the lacerations and possible septic skin condition you induce by your scratching may exceed in severity the entity which caused you to scratch, you must be more pitied than blamed. Only you are aware of how crazy you are to resort to almost scratching yourself to death—sometimes in spite of the prior application of many types of anti-itch preparations. A visit to your sympathetic dermatologist, before the draft physical, might be very rewarding if you have trouble like this.

b. "Fungus infections, systemic or superficial types: If extensive and not amenable to treatment."

"Systemic" fungus infection means infection of the lungs, bowel and other internal bodily organs by fungus disease. These are, in the main, very serious, and sometimes life-threatening diseases which, should you be so afflicted, not only will you not be drafted, but you should count yourself lucky if you manage to recover completely from the illness. I won't discuss them further.

"Superficial" fungus infections are the ailments with which everyone is familiar under the titles, "athlete's foot," "ringworm," etc. From the practical point of view I will confine my comments to the common tinea infections. These are skin conditions caused by a fungus in certain areas of the body. Included are *Tinea axillaris* (in the armpit), *Tinea cruris* (around the genital area), and, most important in this discussion, *Tinea pedis* ("athlete's foot").

For those of you who have suffered from "athlete's foot" the condition needs no description. You will be aware that should it really get a firm footing (no pun in-

tended); it takes quite a lot of treatment to cure; treatment includes frequent foot washing, changing socks like mad and the application of certain types of ointment. Sometimes you may have had to take antibiotics and other medication internally in order to affect a cure. You will know too, that it is notoriously liable to recur, especially if you engage in communal sporting events where the ground is damp and you are bare-footed—at a swimming pool, for instance.

For the uninitiated, the condition consists of “soggy” white skin between the toes, which in places rubs off, leaving raw areas. This is the mildest degree. Later the disease may spread and form blisters and thickening of the skin along the sides of the feet, the insteps, and on to the backs of the feet. In severer cases, the blisters may fill with pus, and the thickened skin split to form painful cracks, which may also get infected, and you may end up with a severely infected leg. If the condition is not adequately treated, you may be left with the chronic form, which never quite clears up and recurs at intervals.

All doctors—including the army physicians—know that this ailment could be aggravated by having to wear the heavy army socks and boots, especially if you are then obliged to engage in strenuous activity conducive to sweating, or live in a hot part of the world, i.e., Vietnam!

If you can produce evidence from any medical source that you have suffered from this condition, especially if you have had it more than once, or it has reached the chronic stage, the military may consider you a “bad risk,” likely to cause them more trouble than you are worth. You’ll be rejected as physically unfit. Even if they do take you in, you’ll hardly go to Vietnam. So, cheer up. Even that is something!

i. “Furunculosis. Extensive, recurrent, or chronic.”

Furunculosis simply means boils. These, as everyone knows, can occur in any part of your body and have a predilection for hairy areas, such as the back of the neck,

under the armpits, and in the groin. They would need to be very disfiguring and cover an extensive area, or keep cropping up like mad, before you would have a hope in hell of being turned down on those grounds alone.

Recurrent boils, however, can be important in so far as this can be one of the early manifestations of diabetes. But your pre-draft examiner will be well aware of this, and will carry out the appropriate tests on your blood and urine.

j. "*Hyperhidrosis* of the hands and feet: Chronic or severe."

This is a condition characterized by an increased tendency towards sweating. In its extreme form, which is meant here, it is not a common condition and is almost invariably found in highly nervous, tense individuals. It is often a hereditary ailment, and may affect the whole body or certain areas only, e.g., as the hands and/or feet.

In its extreme form it can be a very troublesome and aesthetically unattractive condition. However, it is on account of the skin conditions to which sufferers are prone that it assumes medical importance. These include skin troubles called intertrigo, sudamina, and other rarities.

I don't really know how much emphasis should be placed on this condition as an isolated entity for rendering you uninductable. Your doctor will probably enlist the aid of a dermatologist. However, I do know that certain drugs of the atropine group are occasionally used in severe cases. Side effects of such medication include dryness of the mouth, constipation, difficulty with urination, and impotence. What army would want you in such a state!

a. "*Tattoos on any part of the body* which in the opinion of the examining physician are obscene or so extensive on exposed areas as to be considered unsightly, are administratively disqualified."

Here we get into the realm of the ridiculous. As I interpret this paragraph I must conclude, ludicrous though it seems, that should you have a tattoo made on the back of your left hand reading "Agnew is a prick" or on your right "Fuck the army"—especially should the latter extend along the inner border of your hand so as to be obvious when you salute an officer—you would be excluded from the draft.

This is a comical situation, but let's face it, *we* didn't make the rules. *They* did!

SECTION XVIII.

SPINE, SCAPULAE, RIBS, AND SACROILIAC JOINTS

"So little in his purse, so much on his back."

—Joseph Hall, Bishop of Norwich, c. 1600

Back trouble, with the possible exceptions of varicocele, bronchial asthma, and flat feet, is responsible for more cases of rejection for military service than any other ailment.

Back trouble may "kill" you at times, and you may occasionally get the urge to get the whole thing taken out and have done with it, but think carefully before doing anything rash. Even a slight defect in that upright column of yours may be a blessing in disguise.

In the beginning of this book I referred to "subjective symptoms" and "objective findings," and pointed out that in many instances the former were not backed up by the latter, and that furthermore, such was not necessary for classifying a patient as suffering from any particular disease.

In the majority of diseases of the spine listed in this section, not only does the above hold true, but there are many instances where "objective findings" are present even in the absence of any "subjective symptoms." Your "disease" is handed to you on a plate as it were, without your even asking for it! As an example take the following.

In one particular survey, the lower backs of 1000 consecutive applicants for jobs in a certain industry were

X-rayed (Rombold 1960). No less than six hundred and sixty were discovered to have some significant abnormality of the lumbo sacral spine.

Yet another investigation was undertaken (Splithoff 1953), in which the spines of 100 people with complaints of low back pain were X-rayed. Following this, X-rays were taken of another 100, who had no symptoms. This study revealed that abnormal X-ray findings were just as frequent in one group as in the other.

Lest you now are jumping out of your skin with excitement, let me hasten to add that there are many examples of genuine, severe low-back pain that demonstrate no X-ray abnormality, and where we are forced to fall back on the good old "subjective symptoms" alone.

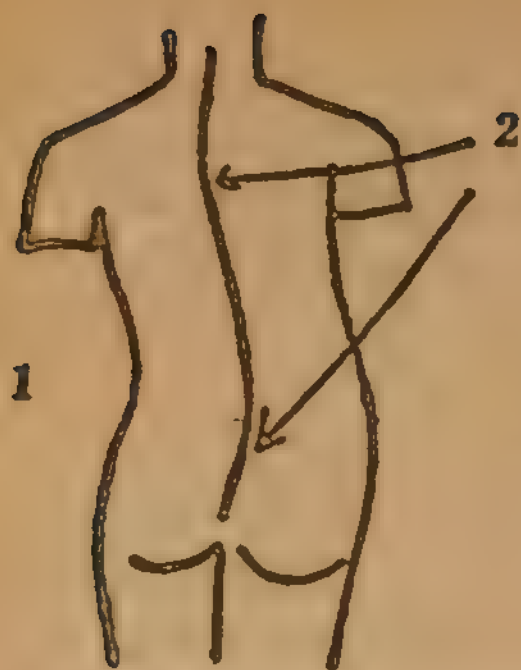
2-36. *"Spine and Sacroiliac Joints.*

b. "Complaint of disease or injury of the spine or sacroiliac joints, either with or without objective signs and symptoms which have prevented the individual from successfully following a physically active vocation in civilian life. Substantiation or documentation of the complaint without symptoms and objective signs is required."

It is a condition of this exclusory regulation that you must have been incapable of "successfully following a physically active vocation." Therefore, if you happen to be an active professional wrestler, or if you hardly ever missed a day off your job as a longshoreman (my previous remarks notwithstanding), or if you competed successfully in the recent Olympic Games, you will undoubtedly have a difficult time convincing them that you are now a cripple—subjective symptoms or not.

c. "Deviation or curvature of the spine from normal alignment, structure, or function (scoliosis, kyphosis, or lordosis, spina bifida occulta, spondolysis, etc.) if—"

Some degree of asymmetry of the spinal column is a relatively common finding even in the absence of symp-



1. *Scoliosis*
2. Note the two “compensatory” curves
3. *Kyphosis*
4. *Lordosis*

toms. More pronounced deviations from normal are often encountered in adolescents and young adults, especially “postural” scoliosis—caused by continually slouching over your desk at school. A more severe form results from a disparity in the length of your legs. Lordosis too (see diagrams) is common in young adults, as is kyphosis of a moderate degree (especially in the upper back region in young girls). Of course, it’s commoner in the aged.

The conditions regarding the degree of incapacity such deformity causes you, which are listed in (1), (2), (3) and (4) depend to a great extent on you the sufferer. Should you also fit into category (5)—abnormal X-ray findings—you’re in great shape!

Incidentally, one of the conditions listed above, spina bifida occulta, a very common congenital deformity of one of the vertebrae, usually only discovered incidentally on routine X-ray examination, and rarely of any clinical consequence, has been the subject of a recent directive and may serve to give you a simple “out” if you have it.

Directive of Oct. 15, 1969:

17. Examinees with spina bifida occulta who have back symptoms are medically disqualified. Orthopedic consultations are not necessarily needed to evaluate such individuals."

d. "*Diseases of the lumbosacral or sacroiliac joints* of a chronic type and obviously associated with pain referred to the lower extremities, muscle spasm, postural deformities and limitation of motion in the lumbar region of the spine."

They really lean over backwards here. "Disease" could mean almost anything, and as I look again at this stipulation, it strikes me that they could just as easily have said: "If you ever had any trouble with your back at any time, we won't be troubling you."

How does the doctor go about examining your back? In case some of you have never had the pleasure of a back examination and don't know what goes on, let me give you the following rough description.

First, you strip to your nothings. Then you stand, feet together, while the doctor inspects your back for signs of curvature or other deformity. He may run his fingers down along your back in confirmation. He then thumps lightly with his fist along the length of your spine to note any areas of tenderness, and over your sacroiliac joints for the same reason.

Then he requests you to bend and touch your toes, keeping your knees straight. You should normally be able to bend to about 90 degrees. You straighten up, and he estimates how far you can bend in a backward direction, while he takes pains to ensure that you don't keel over and bang your head against the floor. Then, grasping both your shoulders, he bends you sideways, first to one side and then to the other, and notes any pain, muscle spasm, or any limitation of what should be a normal range of movement. Then he twists you to the right and to the left to test your "rotatory" movements.

Next, you lie flat on your back on the examination

couch and he measures the length of your legs from the top of the hip bone to the heel. He then performs what is known as the SLR, or straight-leg-raising test, which as the name suggests, means that he raises each of your legs in turn, keeping the knee straight, and estimates how far he can bend you at the hip (which should normally be as far as about a right angle). At the height of this procedure, he may suddenly bend up (dorsiflex) your ankle to see if any pain you have to begin with is thereby augmented. The SLR and ankle bending tests are characteristically positive—that is, pain comes on at a much earlier stage in the leg raising—in cases of “slipped disc.”

The final part of the examination consists of testing your knee and ankle jerks, and in estimating whether you have an equal amount of feeling (sensation) in all areas of both lower limbs.

In any case of back “trouble,” the movement most commonly restricted is forward flexion (bending forward) of the spine. Many “Oohs” and “Ahs” are uttered during this maneuver, and even in cases of quite minor back strain this movement may be severely limited. The same holds true to a lesser extent for lateral flexion (bending to the side) and rotation, although in the case of these movements the limitation will be more restricted depending on which side of the back has been “wrenched.” Rotation is especially limited in trouble involving either sacroiliac joint, for it throws an added strain on the joint when you twist to the opposite side. Lateral flexion (also to the opposite side) will do it too.

Remember, however, that “objective findings” don’t have to be demonstrated. However, such abnormal findings though would certainly help to substantiate and lend strength to your “case.”

g. “Ruptured nucleus pulposus (herniation of intervertebral disc) or history of operation for this condition.”

This is the very common “slipped disc,” and if severe, will pose little diagnostic problems. The X-ray of your

back will be abnormal and show a narrowing of the space in between two contiguous vertebrae (commonly between the fourth and fifth lumbar). Examination will reveal limitation of forward spinal flexion, possibly also eliciting pain which shoots down one leg or other to the ankle. The SLR test on the affected side will be short of normal, and the ankle (and possibly also the knee) jerk will be diminished or absent on that side. You may also have diminished feeling on the affected side, especially around the outside of the foot and ankle and to some extent up along the outside of your leg. You can hardly fake all this, but if you have the ailment you won't have to!

A further (and quite superfluous) directive about discs and opeartion follows.

Directive of July 22, 1969:

4. History of spinal fusion is considered disqualifying."

b. "Spondylolysis or spondylolisthesis that is symptomatic or is likely to interfere with performance of duty or is likely to require assignment limitations."

And herewith another directive.

Directive of Oct. 15, 1969:

18. Spondylolysis and spondylolisthesis are disqualifying for registrants regardless of symptoms. Applicant's papers documenting asymptomatic spondylolysis or spondylolisthesis may be forwarded to the Office of the Surgeon, USAREC, for consideration of a waiver."

These two conditions, though not uncommon, concern us little for, as quoted above, if you are so afflicted, you're undraftable. Briefly, however, Spondylolisthesis means that the fifth lumbar vertebra, the last single member of the column, has shifted too far forward, straining ligaments and causing trouble. In spondylolysis, not only

does the vertebra move forward, but it breaks off from part of itself and leaves it behind. If you get the gist of all this, you're a genius!

Finally, it is perhaps superfluous to reiterate, that should you suffer from any form of backache, regardless of severity, such symptoms are *yours*. While some positive findings would lend credence to your claims—including, of course, the all important X-ray abnormality—they are not necessary. All you need to be uninductable is: “. . . substantiation or documentation of the claim, *without* (my italics) symptoms and objective signs . . .”

A word of warning: All that glitters isn't gold, and your doctor will be well aware that all cases of backache aren't caused by musculo-skeletal conditions. Kidney disease etc., can cause it, and should your doctor suspect such entities, he will undoubtedly rule them out by carrying out the appropriate tests.

SECTION XIX.

SYSTEMIC DISEASES AND MISCELLANEOUS CONDITIONS AND DEFECTS

“. . . Surely the age will dawn in which the strong are just and the weak secure and the peace preserved.”

—John Fitzgerald Kennedy, Address at Berkeley, March 23, 1962

2-39. “General and Miscellaneous conditions and defects.

a. *“Allergic manifestations.*

(5) Bona fide history of moderate or severe generalized (as opposed to local) allergic reaction to insect bites or stings. Bona fide history of severe generalized reaction to common foods, e.g., milk, eggs, beef, and pork.”

In this instance a “bona fide history” is the important and significant part of the statement. It ill behoves anyone not to believe you when you relate how you went all faint and had chills and sweated like mad, and thought for a while that you were going to die, when you were bitten by a wasp while strolling in the hills by yourself. (A little wheal where he stung you isn’t enough, remember.)

The army isn’t prepared to take risks with a “sensitive” fellow like you. Besides, there are wasps the size of elephants, and other “blood-letters” you have never even heard of over in Vietnam!

If your stomach cannot tolerate anything more mundane than champagne and caviar, then you’d have to starve and . . .

In this "allergic" context, a condition not included in this issue of Chapter Two:

Directive of July 22, 1969:

15. "Examinees who give a history of wool allergy but have no documentation other than a positive skin test to wool may be requested to wear wool socks for three days and return to AFEES to be examined for evidence of allergic reaction."

How is anyone to know (and how dare they insist) that you wore the socks? Maybe you decided to wear nylon socks instead and found that you were allergic to *that*, or . . . or . . .

h. "Heat pyrexia (heatstroke, sunstroke, etc.): Documented evidence of predisposition (includes disorders of sweat mechanism and previous serious episode), recurrent episodes requiring medical attention, or residual injury resulting therefrom (especially cardiac, cerebral, hepatic, and renal)."

During the summer in all parts of the United States, and all year round in California and other warm parts of the nation, this is by no means rare. It is often discovered among Boy Scout and other groups of lovers of the great outdoors who wander around mountains and deserts and get all worn out, sweat a lot, and become dehydrated and exhausted.

You would hardly need to end up in a hospital, or to fulfil the harsh criteria described above. All that is required, is that you present the facts to your doctor, corroborated if possible by the testimony of a friend, or the scout-master or whomever. If he doesn't believe you, then go out again and really show him!

Last year I had occasion to submit evidence of such an occurrence to the draft board on behalf of one of my patients of who had suffered from a mild case of heat exhaustion while on a camping trip to Death Valley. With

the desired result. Death Valley (name notwithstanding) isn't anything like as "hot" as My Lai, for instance!

k. *"Myositis and fibrositis; severe, chronic."*

This could include just about any ache or pain you ever had in any part of your body during the course of your life.

Myositis, literally, inflammation of muscle, and fibrositis, inflammation of fibrous tissue (ligaments, sinews) is most commonly found around the shoulder blades, in the neck, or in any part of the back.

Although commoner in older people, it is by no means an exclusively geriatric ailment. You too could suffer agonies from it. Depending on the kind of dissipated life you have led up to now, you could already have caused premature aging of your torso!

* * * * *

SECTION XX.

TUMORS AND MALIGNANT DISEASES

Nothing concerns us here. A malignant tumor and you're more or less a "goner" anyway, and the applicable "benign" ones have been considered in other sections.

SECTION XX. VENEREAL DISEASES

" 'Tis better to have loved and lost
Than never to have loved at all."

—Alfred Lord Tennyson, *In Memoriam*.

Nearly all of the following is self explanatory

2-42. "Veneral Diseases.

"In general the finding of acute, uncomplicated venereal disease which can be expected to respond to treatment is not a cause for medical rejection for military service. The causes for rejection for appointment, enlistment, and induction are . . .

a. "*Chronic venereal disease* which has not satisfactorily responded to treatment. The finding of a positive serological test for syphilis following the adequate treatment of syphilis is not in itself considered evidence of chronic venereal disease which has not responded to treatment (para 2-39f)."

And

Directive of Jan. 24, 1969:

26. "Serology."

a. "The interpretation of Chapter 2-39f, AR 40-501 with regard to positive serologies has caused some confusion. For clarification, the following is offered: An individual with a positive RPR should be tempo-

rarily rejected until the Public Health Service reviews the case and treats the applicant if necessary. The examinee will then return to AFEEES with documentation of adequate therapy. If, on return, repeat serology remains reactive, but there is no evidence of residuals or complications, the individual is then acceptable."

You can't stop them now!

Directive of Oct. 15, 1969:

15. "Examinees with a positive serology do not have to be treated before entering on active duty. They will be treated after entering military service."

I wish they'd make up their minds! You Don Juans can't wait around forever!

It would appear when one has sifted through all the (sometimes contradictory) rules and regulations above, that they will still have you, syphilis or no, provided that it has been "adequately treated" but *not necessarily* (my italics) proven to be cured. Trust the army!

They still want you—"acute, uncomplicated venereal disease"—even with a dose of the "clap"!

If that's not the final irony!

CONCLUSION

Many years ago an Irish patriot by the name of Daniel O'Connell said: "Freedom isn't worth the spilling of one drop of Irish blood . . . I could drive a coach-and-four through any Act-of-(British)-Parliament." While I can hardly lay claim to having effected such an achievement with this book, it was nevertheless inspired by similar sentiments.

I have attempted to extract from each section diseases and syndromes which I have found from experience to be the most controversial and "borderline," and which I considered most likely to be of use to you in your fight against the draft. I hope that I have succeeded in my task with a modicum of success.

Of necessity, there remain many ailments in each section—some common, some rare—which I haven't touched. I would advise you therefore, to go and ask your doctor's advice, if you have, or even think you have, any of these.

As I emphasized in the beginning of the book, your chances of avoiding the draft will be immeasurably enhanced if you are lucky enough to find a doctor who is sympathetically disposed towards you and your position. Such a man, as far as you're concerned, may well be worth his weight in gold, and he is available for no more than a few dollars. However much you pay, it will be money well spent.

Seek him assiduously. And if you fail, you could always take a trip to Santa Barbara.

APPENDIX A

These addresses of various Draft Counseling Services throughout the United States are as reasonably up-to-date and accurate as possible at the time of writing. Many of them will undoubtedly have changed their location or ceased to exist, and many will have been added by the time this book is in print. Like the weather, they are subject to constant change. As a general rule, your local university, or city or state college will be able to help you in this regard.

Southwest and West

Denver, Colorado 80203: American Friends Service Committee, 1460 Pennsylvania Street; 303/534-6285

Laramie, Wyoming 82070: Draft Information Center, 205 S. 11th; 307/742-3791

Tucson, Arizona 85701: Draft Counseling Service, 513 Arizona Land Title Building; 602/623-7951

Pasadena, California 91102: American Friends Service Committee, 980 N. Fair Oaks (P.O. Box 991); 213/791-1978

Santa Barbara, California 93017: Switchboard, 6575 Seville, Goleta; 805/968-3565

San Francisco, California 94110: Draft Help, 3684-18th Street; 415/863-0775

Hayward, California 94541: Hayward Peace Center, 2010 B Street; 415/581-4015

Berkeley, California 94704: East Bay Draft Information and Counseling Center, 2320 Dana Street, Room 5; 415/841-7400

Sacramento, California 95816: Sacramento Peace Center, 3720 Folsom Boulevard; 916/457-5587

Honolulu, Hawaii 96822: American Friends Service Committee, 2426 Oahu Avenue (P.O. Box 5199, Honolulu 96814); 808/988-6266

Portland, Oregon 97214: Portland Draft Counseling Center, 215 S.E. 9th Avenue; 503/232-5946

Portland, Oregon 97215: American Friends Service Committee, 4312 S.E. Stark; 503/235-8954 (No counseling, but will refer you to counselors in southern Idaho, Wyoming and Oregon)

Eugene, Oregon 97403: Draft Information Center, Erwin Memorial Union, University of Oregon; 503/342-1411, ext. 321

Seattle, Washington 98105: American Friends Service Committee, 814 N.E. 40th Street; 206/632-0502

Bellingham, Washington 98225: Western Washington State College Draft Counseling Service, Viking Union Building; 206/734-8800, ext. 2265

South

Washington, D.C. 20008: Washington Peace Center, 2111 Florida Avenue, N.E.; 202/234-2000

Baltimore, Maryland 21218: American Friends Service Committee, 319 E. 25th Street; 301/467-9100

Norfolk, Virginia 23507: Tidewater Draft Counseling Service, Unitarian Center, 902 Graydon Avenue; 703/627-9851

High Point, North Carolina 27260: American Friends Service Committee, 1818 S. Main Street; 919/882-0109

Chapel Hill, North Carolina 27514: Chapel Hill Draft

- Counseling Service, 110 Church Street (P.O. Box 202); 919/929-1737
- Durham, North Carolina 27705: Durham Draft Counseling Service, c/o Durham Friends Meeting, 404 Alexander Avenue; 919/286-4958
- Charlotte, North Carolina 28207: Charlotte Draft Counseling Service, 2039 Vail Avenue; 704/333-3979, 525-2501
- Columbia, South Carolina 29202: Columbia Draft Information Service, Columbia Building, Suite 704 (P.O. Box 1283); 803/253-4123
- Atlanta, Georgia 30303: American Friends Service Committee, 41 Exchange Place, S.E.; 404/523-6628
- Atlanta, Georgia 30309: Atlanta Worship in Nonviolence, 946 W. Peachtree Street (P.O. Box 7477); 404/875-0646
- Augusta, Georgia 30904: Augusta Draft Information Service, c/o Marguerite Rece, 3021 Fox Spring Road; 404/738-5262
- Tallahassee, Florida 32301: Tallahassee Draft Counseling Service, Westminster House, 548 W. Park Street; 904/224-6768, 576-6850
- Miami, Florida 33133: AFSC Peace Center of Miami, 3356 Virginia Street, Room 202; 305/443-9836
- St. Petersburg, Florida 33705: Tampa Bay Area Peace Center, AFSC, 130-19th Avenue, S.E.; 815/894-0708
- Knoxville, Tennessee 37916: Knoxville Draft Counseling Service, c/o Tyson House, 824 Melrose Place; 615/523-5373
- Greenville, Mississippi 38701: Rims Barber, The Delta Ministry, 723 Nelson Street (Box 457); 601/334-4587
- Louisville, Kentucky 40206: Louisville Peace Council, Southern Seminary, Box 572; 502/893-3084
- Louisville, Kentucky 40218: Friends Meeting of Louisville, 3050 Bon Air Avenue; 502/454-6812
- Lake Charles, Louisiana 70601: Rev. Homer C. Singleton, Jr., 501 E. Sale Road; 318/477-2191, 477-3432
- Baton Rouge, Louisiana 70803: John Woolman Fellowship (Quakers), L.S.U. Union, Louisiana State University; 504/388-2338, 388-2545, 388-5356

Tulsa, Oklahoma 74106: Tulsa Draft Counseling and Information Service, 2330 N. Quaker (P.O. Box 6006); 918/345-4765

Waco, Texas 76706: Baylor Committee to End War, Box 6395; 817/752-4886

Houston, Texas 77003: Draft Counseling Service of Houston, 102 N. Sampson Street; 731/747-0781, 225-4642 (night)

Austin, Texas 78705: Austin Draft Information Center, 2200 Guadalupe; 512/477-3480

Midwest

Columbus, Ohio 43201: Columbus Draft Project, St. Stephen's Church, 30 W. Woodruff; 614/291-5983

Toledo, Ohio 43604: Draft Information and Counseling Service, 401 Board of Trade Building; 419/242-7405

Cleveland, Ohio 44106: Draft Counseling Association, 11205 Euclid Avenue; 216/795-3210

Akron, Ohio 44308: Akron Draft Counseling Association, 101 S. Main Street; 216/376-4116

Youngstown, Ohio 44503: Clergy & Laymen Concerned Draft Information Service, 213-½ N. Phelps Street; 216/744-0754

Cincinnati, Ohio 45220: Cincinnati Draft Information Service, 2699 Clifton Avenue; 513/861-5933

Dayton, Ohio 45406: American Friends Service Committee, 915 Salem Avenue; 513/278-4225

Springfield, Ohio 45502: Draft Information Center, 33 N. Fountain; 513/325-1361

Athens, Ohio 45701: United Campus Ministry Draft Counseling Center, 18 N. College Street; 614/593-7301

Indianapolis, Indiana 46202: Indianapolis Draft Project, 222 E. 16th Street; 317/923-9563

Valparaiso, Indiana 46383: Valparaiso University Draft Counseling Service, 818 Mound Street; 219/462-6215, 462-5111, ext. 444

Gary, Indiana 46409: Lake County Draft Information Center, 3525 Jefferson Street; 219/887-5497

South Bend, Indiana 46617: South Bend Draft Union, 526 N. Hill Street; 219/232-3275

- Fort Wayne, Indiana 46805: Fort Wayne Selective Service Information Center, P.O. Box 5144; 219/743-5371
- Bloomington, Indiana 47401: Bloomington Draft Project, 101-½ W. Kirkwood Room 2; 812/332-1849
- Terre Haute, Indiana 47801: Terre Haute Draft Project, 677-½ Wabash Avenue; 812/235-1270
- West Lafayette, Indiana 47906: Purdue Draft Counseling Service, 435 State Street (Box 3024); 317/743-3861
- Rochester, Michigan 48063: Ken Colton, Wesley Foundation, 3920 Walton Boulevard; 313/338-9269
- Ann Arbor, Michigan 48104: American Friends Service Committee, 1414 Hill Street; 313/761-8283
- Ann Arbor, Michigan 48108: Ann Arbor Draft Counseling Center, 502 E. Huron Street; 313/769-4414
- Detroit, Michigan 48226: Detroit Draft Counseling Service, Central Methodist Church, 23 E. Adams; 313/838-5620
- East Lansing, Michigan 48823: Draft Information Center, 507 E. Grand River, Suite 205; 517/351-5283
- Kalamazoo, Michigan 49001: Kalamazoo Draft Counseling Committee, 2407 S. Rose Street; 616/349-1754
- Grand Rapids, Michigan 49502: Draft Information Center, 129 E. Fulton; 616/454-8427
- Marquette, Michigan 49855: Rev. Lothar Pietz, Wesley Foundation, 307 W. Fair; 906/225-1945, 225-1963
- Ames, Iowa 50010: United Campus Christian Ministry, 2330 Lincoln Way; 515/232-1472, 292-2376
- Grinnell, Iowa 50112: Grinnell Draft Information Center, 1205 Park Street, Grinnell College; 515/236-6181, ext. 355
- Des Moines, Iowa 50312: American Friends Service Committee, 4211 Grand Avenue; 515/274-0453
- Cedar Falls, Iowa 50613: Draft Information and Counseling Service, 818 W. Seerley Boulevard; 319/266-3437
- Iowa City, Iowa 52240: Hawkeye Area Draft Information Center, 204 Dey Building, Iowa Avenue & Clinton Street; 319/337-9327
- Milwaukee, Wisconsin 53211: UWM Ecumenican Center, 2211 E. Kenwood Boulevard; 414/962-5460

Milwaukee, Wisconsin 53233: Milwaukee Area Draft Information Center, 1611 W. State Street; 414/342-0191
 Beloit, Wisconsin 53511: Beloit Anti-Draft Union, 1015 Chapin Street; 608/362-4237
 Madison, Wisconsin 53703: American Friends Service Committee, 211 Langdon Street; 608/257-5131
 Stevens Point, Wisconsin 54481: Stevens Point Draft Information Service, 1125 Fremont Street; 715/344-0034
 LaCrosse, Wisconsin 54601: The United Campus Ministry, 126 N. 17th Street; 608/784-7600
 Eau Claire, Wisconsin 54701: Eau Claire Draft Information Center, 110 Garfield Avenue; 715/834-7781
 Minneapolis, Minnesota 55414: American Friends Service Committee, 807 Fourth Street, S.E.; 612/332-1529
 Minneapolis, Minnesota 55404: Twin Cities Draft Information Center, 529 Cedar Avenue South; 612/333-8471, 333-3717
 Duluth, Minnesota 55806: Duluth-Superior Draft Information Center, 25 W. 4th Street; 218/727-5697
 Mankato, Minnesota 56001: Fr. Timothy Hallett, Joint Ministry Center, 331 Dillon Avenue; 507/387-3419
 Bozeman, Montana 59715: Ray T. Moore, 717 S. 14th Avenue; 406/586-2916
 DeKalb, Illinois 60115: DeKalb Association for Draft Counseling, 633 W. Locust Street; 815/758-0005
 Maywood, Illinois 60153: West Suburban Draft Counseling Center, 100 S. 19th Avenue; 312/344-2343
 Evanston, Illinois 60202: North Shore Draft Information Service, 926 Chicago Avenue; 312/475-2260
 Naperville, Illinois 60540: Naperville Council of Churches—Selective Service Information Center, 34 S. Washington Street; 312/355-0210
 Chicago, Illinois 60605: American Friends Service Committee, 407 S. Dearborn Street; 312/427-2533
 Mt. Carroll, Illinois 61053: Northwest Illinois Draft Information Service, c/o Rev. Don P. Moon, Shimer College; 815/244-7255
 Peoria, Illinois 61603: Peoria Draft Information Center, 908 Hamilton Boulevard; 309/673-5391

Champaign, Illinois 61820: Champaign-Urbana Selective Service Information and Counseling Service, YMCA, 1001 S. Wright Street; 217/344-1351
Carbondale, Illinois 62901: Draft Information Service, Student Activities Center, University Center; 618/457-2222
St. Louis, Missouri 63130: Peace Information Center, 6244 Delmar Boulevard; 314/862-5735
Kansas City, Missouri 64111: Vietnam Information Center, 306 W. 39th Street; 816/753-1619
Lawrence, Kansas 66044: Lawrence Peace Center, 107 W. 7th Street; 913/842-7932
Manhattan, Kansas 66502: Service Careers and Information Center, 1021 Denison Avenue; 913/539-4281
Wichita, Kansas 67214: Wichita Draft Information and Counseling Service, 607 N. Broadway; 316/264-9303, 267-4201
Omaha, Nebraska 68104: Draft Information Service, 1616 N. 51st Street; 402/553-5316

Northeast

Amherst, Massachusetts 01002: Valley Peace Center, 1 Cook Place (P.O. Box 418); 413/253-3683
Worcester, Massachusetts 01602: Draft Information Service, 134 Chandler Street; 617/755-8170
Cambridge, Massachusetts 02138: Draft Information Center, 5 Longfellow Park (Friends Center); 617/876-7939
Brookline, Massachusetts 02146: Brookline Draft Counseling Service, c/o Sherman, 173 Davis Avenue; 617/731-2063
Manchester, New Hampshire 03101: Community Information and Service Center, 47 Manchester Street; 603/623-9412
Concord, New Hampshire 03301: Concord Peace Center, 9 Pleasant Street; 603/744-3702
Portland, Maine 04101: Draft Counseling Service of Southern Maine, 132 Park Street; 207/773-6964
Hartford, Connecticut 06106: Capitol Area Action

Movement, 106 Ward Street (P.O. Box 1643, Station A); 203/278-2897
 New Haven, Connecticut 06501: Draft Action Group—Resistance, 532 State Street (P.O. Box 1448); 203/865-4982
 New Haven, Connecticut 06511: New Haven Draft Information Center, 425 College Street; 203/624-6657
 Princeton, New Jersey 08540: Draft Information Center, 173 Nassau Street; 609/924-5487
 New York, New York 10003: American Friends Service Committee, 15 Rutherford Place; 212/777-4600
 New York, New York 10012: War Resisters League, 339 Lafayette Street; 212/267-4592
 Scarsdale, New York 10583: Draft Counseling and Information Service of Westchester, Box 42, Heathcote Station; 914/723-5439
 Great Neck, New York 11023: Long Island Draft Information & Counseling Service, P.O. Box 125; 516/931-5765
 Brooklyn, New York 11215: Brooklyn Draft Information and Counseling Service, 53 Prospect Park West (Ethical Culture); 212/768-3701
 Albany, New York 12208: Capitol Area Peace Center, 727 Madison Avenue; 518/463-8297
 Poughkeepsie, New York 12603: Draft Counseling and Information Service of Dutchess County, 249 Hooker Avenue; 914/471-9616
 Syracuse, New York 13224: Syracuse Peace Council, 3049 E. Genesee Street; 315/446-5656
 Ithaca, New York 14850: Cornell Draft Information Service, 316 Anabel Taylor Hall, Cornell University; 607/275-4229
 Pittsburgh, Pennsylvania 15213: Draft Information Center, 4401 Fifth Avenue; 412/682-2751
 Philadelphia, Pennsylvania 19102: The Draft Information Center, 153 N. 16th Street; 215/563-4431, 563-6474
 Wilmington, Delaware 19801: Delaware Draft Counseling and Educational Service, 1106 N. Adams Street; 302/658-7602

APPENDIX B

Memorandum on Medical Appeals

A registrant may attempt to obtain I-Y or IV-F classification due to medical disqualification in one of three ways:

1. The registrant may appeal through the normal appeal processes, requesting a personal appearance and later appealing to the State Appeal Board, provided that he takes his initial appeal action within thirty days of the date on which a Notice of Classification was sent to him. The Notice of Acceptability mailed to the registrant after his pre-induction physical examination is not a Notice of Classification and does not entitle the registrant to appeal the process described above. Since the registrant is normally classified I-A prior to his pre-induction physical exam, he should always request a personal appearance before his local draft board within thirty days of the date the Notification of Classification is mailed to him to safeguard his rights in the event that he passes the pre-induction physical exam. The normal S.S. appeal process may result in a re-evaluation physical examination but is normally not satisfactory.

2. The registrant may also seek an interview with the

Medical Adviser to his local draft board under Part 1628 of the S.S. Regulations. This interview may be requested any time after the registrant is classified I-A. A registrant who requests an interview with the Medical Adviser to his local draft board may precipitate a premature pre-induction physical exam by his action. Draft boards frequently attempt to avoid giving interviews with their Medical Advisers by ordering the registrant to take a pre-induction physical exam in lieu of the interview. Accordingly, one should wait until he is ordered to report for his pre-induction physical exam and immediately request the interview with the Medical Adviser along with a request for a postponement or cancellation of the pre-induction physical. If the registrant has previously had a pre-induction physical exam and has been found to be acceptable, he may request an interview with the Medical Adviser under Part 1628 of the SSR, but Gen. Hershey has ruled that an interview will not be granted subsequent to a pre-induction physical exam.

3. The most satisfactory way to request a I-Y or IV-F classification is to proceed through the office of The Surgeon of the United States Army Recruiting Command in Hampton, Virginia. The registrant should be advised to obtain a recent medical report, describing his condition in great detail—giving a medical history, a diagnosis of his present condition, a prognosis for future recovery, and a description of how military training will affect the registrant's well-being. At the time the registrant is ordered to report for his pre-induction physical exam, copies of all medical records and reports should be sent to his draft board with the request that they be forwarded to the induction center at the time of his pre-induction physical exam. The registrant should keep a separate copy of each medical record and report to take with him to the examining station. A third set of records should be retained by the registrant for future action. In the event the registrant is found medically acceptable at the examining station, he should write immediately to:

Lt. Col. George W. Sgalitzer
The Surgeon, U.S. Army Recruiting Command
Hampton, Virginia 23369

In his letter to The Surgeon, the registrant should indicate that he has completed his pre-induction physical exam and has been found acceptable. He should enclose copies of his medical records and reports and request The Surgeon to review the findings of the local induction center and to direct that he be found medically disqualified, or, in the alternative, to order that the registrant be re-examined at the induction center immediately. In the event of an unfavorable reply from the office of The Surgeon, the registrant should write to:

Col. Ralph R. Chapman, Chief
Physical Standards Division
Department of the Army
Office of The Surgeon General
Washington, D.C. 20315

In his letter to Col. Chapman, the registrant should point out that he has previously appealed to Lt. Col. Sgalitzer and has been rejected at that level. The registrant should request that Col. Chapman intervene personally and review the medical records, all of which should be forwarded with the registrant's letter. In the event that the U.S. Army Recruiting Command finds some doubt concerning the medical acceptability of the registrant, normal procedure is to order the registrant to report for a re-evaluation physical exam immediately. Such re-evaluation physical exams are often quite thorough and our experience has been that approximately 75% of such appeals are successful.

In the event that the registrant faces imminent induction, his letter to The Surgeon of the U.S. Army Recruiting Command should be sent Air Mail—Special Delivery, or he should telegraph the Office of the Army Recruiting Command asking their immediate intervention to

postpone the induction pending a review of the medical findings. In cases where time does not permit appeals to the U.S. Army Recruiting Command prior to the induction date, registrants might be well advised to refuse induction if they are found medically acceptable at the induction center physical and to write to the Army Recruiting Command immediately, asking for a review of the medical findings. A copy of such letter should be sent to the registrant's draft board to forestall any punitive action pending further word from the Office of the Army Recruiting Command. The registrant might indicate in such letter that he is willing to submit to induction if The Surgeon determines that he is indeed medically qualified for service.

For individuals who have been inducted, the procedure outlined above may also be attempted. The U.S. Attorney's office will usually agree to dismiss an indictment if the registrant agrees to submit to induction. If the registrant has accumulated sufficient medical records, he should enter into such an agreement with the U.S. Attorney's office and immediately send copies of his records to the Army Recruiting Command informing them that he is about to report for induction. Normally, the registrant follows such a procedure and is examined at the induction center and told to return home pending a review of the examination by the Army Recruiting Command in Hampton, Virginia. If the registrant is found medically unacceptable, the indictment will usually be dismissed. If the registrant is found medically acceptable, the indictment will be re-activated and the registrant must stand trial. However, if the registrant feels that he has a legitimate medical defect, his attorney should argue that there was no basis in fact for his I-A classification on the ground that he was medically disqualified.

APPENDIX C

CHAPTER 2

MEDICAL FITNESS STANDARDS FOR APPOINTMENT, ENLISTMENT, AND INDUCTION

(Short Title:
PROCUREMENT MEDICAL FITNESS STANDARDS)

SECTION I. GENERAL

2-1. Scope

This chapter sets forth the medical conditions and physical defects which are causes for rejection for military service in peacetime. For medical fitness standards during mobilization, see chapter 6.

2-2. Applicability

These standards apply to—

a. Male and female applicants for appointment as commissioned or warrant officers in the U.S. Army, regardless of component. (Special categories of personnel such as physicians, dentists, and other specialists liable for military service under the Military Selective Service Act of 1967 will be procured under standards prescribed by the Secretary of the Army in

appropriate personnel procurement program directives.)

b. Male and female applicants for enlistment in the U.S. Army, regardless of component. These standards are applicable until enlistees have completed 4 months of active duty or active duty for training under the Reserve Enlistment Program 1963 for medical conditions or physical defects existing prior to original enlistment or induction. (See also AR 635-40, AR 635-200, AR 135-178, and NGR 25-3 for administrative procedure for separation for medically unfitting conditions that existed prior to service.)

c. Male and female applicants for reenlistment in the U.S. Army (regardless of component) after a period of more than 90 days has elapsed since discharge.

d. Applicants for the Army ROTC Scholarship Program, the Advanced Course Army ROTC and other personnel procurement programs, other than induction for which these standards are prescribed.

★e. Retention of cadets of the United States Military Academy, except for such conditions that have been diagnosed since entrance into the Academy. With respect to such conditions upon recommendation of The Surgeon General, the medical fitness standards of chapter 3 are applicable to retention in the Academy and subsequent appointment in the Regular

Army or entry on active duty in enlisted status.

f. Registrants who undergo preinduction or induction medical examination pursuant to the Military Selective Service Act of 1967 except medical and dental and allied medical specialists registrants who are to be evaluated under chapter 8.

g. "Draft-eligible" male applicants for enlistment in the U.S. Air Force.

h. Male applicants for enlistment or reenlistment in the U.S. Navy or Naval Reserve.

i. "Chargeable accessions" for enlistment in the U.S. Marine Corps or Marine Corps Reserve.

SECTION II. ABDOMEN AND GASTROINTESTINAL SYSTEM

2-3. Abdominal Organs and Gastrointestinal System

The causes for rejection for appointment, enlistment, and induction are—

a. *Cholecystectomy*, sequelae of, such as postoperative stricture of the common bile duct, reforming of stones in hepatic or common bile ducts, or incisional hernia, or postcholecystectomy syndrome when symptoms are so severe as to interfere with normal performance of duty.

b. *Cholecystitis*, acute or chronic, with or without cholelithiasis, if diagnosis is confirmed by usual laboratory procedures or authentic medical records.

c. *Cirrhosis* regardless of the absence of manifestations such as jaundice, ascites or known esophageal varices, abnormal liver function tests with or without history of chronic alcoholism.

d. *Fistula* in ano.

e. *Gastritis*, chronic hypertrophic, severe.

f. *Hemorrhoids*.

(1) External hemorrhoids producing marked symptoms.

(2) Internal hemorrhoids, if large or accompanied with hemorrhage or protruding intermittently or constantly.

g. *Hepatitis* within the preceding 6 months, or persistence of symptoms after a reasonable period of time with objective evidence of impairment of liver function.

h. Hernia:

(1) Hernia other than small asymptomatic umbilical or hiatal.

(2) History of operation for hernia within the preceding 60 days.

i. Intestinal obstruction or authenticated history of more than one episode, if either occurred during the preceding 5 years or if resulting condition remains which produces significant symptoms or requires treatment.

j. Megacolon of more than minimal degree, *diverticulitis*, *regional enteritis* and *ulcerative colitis*. *Irritable colon* of more than moderate degree.

k. Pancreas, acute or chronic disease of, if proven by laboratory tests, or authenticated medical records.

l. Rectum, stricture or prolapse of.

m. Resection, gastric or of bowel; or *gastroenterostomy*; however minimal intestinal resection in infancy or childhood (for example: for intussusception or pyloric stenosis) is acceptable if the individual has been asymptomatic since the resection and if surgical consultation (to include upper and lower gastrointestinal series) gives complete clearance.

n. Scars.

(1) Scars, abdominal, regardless of cause, which show hernial bulging or which interfere with movements.

(2) Scar pain associated with disturbance of function of abdominal wall or contained viscera.

o. Sinuses of the abdominal wall.

p. Splenectomy, except when accomplished for the following:

(1) Trauma.

(2) Causes unrelated to diseases of the spleen.

(3) Hereditary spherocytosis.

(4) Disease involving the spleen when followed by correction of the condition for a period of at least 2 years.

q. Tumors. See paragraphs 2-40 and 2-41.

r. Ulcer:

(1) Ulcer of the stomach or duodenum if diagnosis is confirmed by X-ray examination, or authenticated history thereof.

(2) Authentic history of surgical operation(s) for gastric or duodenal ulcer.

s. Other congenital or acquired abnormalities and defects which preclude satisfactory performance of military duty or which require frequent and prolonged treatment.

SECTION III. BLOOD AND BLOOD-FORMING TISSUE DISEASES

2-4. Blood and Blood- Forming Tissue Diseases

The causes for rejection for ap-

pointment, enlistment and induction are—

a. Anemia:

(1) Blood less anemia—until both condition and basic cause are corrected.

(2) Deficiency anemia, not controlled by medication.

(3) Abnormal destruction of RBC's: Hemolytic anemia.

(4) Faulty RBC construction: Hereditary hemolytic anemia, thalassemia, and sickle cell anemia.

(5) Myelophthisic anemia: Myelomatosis, leukemia, Hodgkin's disease.

(6) Primary refractory anemia: Aplastic anemia, DiGuglielmo's syndrome.

b. Hemorrhagic states:

(1) Due to changes in coagulation system (hemophilia, etc.).

(2) Due to platelet deficiency.

(3) Due to vascular instability.

c. Leukopenia, chronic or recurrent, associated with increased susceptibility to infection.

d. Myeloproliferative disease (other than leukemia):

(1) Myelofibrosis.

(2) Megakaryocytic myelosis.

(3) Polycythemia vera.

e. Splenomegaly until the cause is remedied.

f. Thromboembolic disease except for acute, nonrecurrent conditions.

SECTION IV. DENTAL

2-5. Dental

The causes for rejection for appointment, enlistment, and induction are—

a. Diseases of the jaws or associated tissues which are not easily remediable and which will incapacitate the individual or prevent the satisfactory performance of military duty.

b. Malocclusion, severe, which interferes with the mastication of a normal diet.

c. Oral tissues, extensive loss of, in an amount that would prevent replacement of missing teeth with a satisfactory prosthetic appliance.

d. Orthodontic appliances. See special administrative criteria in paragraph 7-12.

c. Relationship between the mandible and maxilla of such a nature as to preclude future satisfactory prosthodontic replacement.

SECTION V. EARS AND HEARING

2-6. Ears

The causes for rejection for appointment, enlistment, and induction are—

a. Auditory canal:

(1) Atresia or severe stenosis of the external auditory canal.

(2) Tumors of the external auditory canal except mild exostoses.

(3) Severe external otitis, acute or chronic.

b. Auricle: Agenesis, severe; or severe traumatic deformity, unilateral or bilateral.

c. Mastoids:

(1) Mastoiditis, acute or chronic.

(2) Residual or mastoid operation with marked external deformity which precludes or interferes with the wearing of a gas mask or helmet.

(3) Mastoid fistula.

d. Meniere's syndrome.

c. Middle ear:

(1) Acute or chronic suppurative otitis media. Individuals with a recent history of acute suppurative otitis media will not be accepted unless the condition is healed and a sufficient interval of time subsequent to treatment has elapsed to insure that the disease is in fact not chronic.

(2) Adhesive otitis media associated with hearing level by audiometric test of 20 db or more average for the speech frequencies (500, 1000, and 2000 cycles per second) in either ear regardless of the hearing level in the other ear.

(3) Acute or chronic serious otitis media.

(4) Presence of attic perforation in which presence of cholesteatoma is suspected.

(5) Repeated attacks of catarrhal otitis media; intact greyish, thickened drum(s).

f. Tympanic membrane:

★(1) Any perforation of the tympanic membrane.

(2) Severe scarring of the tympanic membrane associated with hearing level by audiometric test of 20 db or more average for the speech frequencies (500, 1000, and 2000 cycles per second) in either ear regardless of the hearing level in the other ear.

g. Other diseases and defects of the ear which obviously preclude satisfactory performance of duty or which require frequent and prolonged treatment.

2-7. Hearing

(See also para. 2-6.)

The cause for rejection for appointment, enlistment, and induction is—

Hearing acuity level by audiometric testing (regardless of conversational or whispered voice hearing acuity) greater than that described in table I, appendix II. There is no objection to conducting the whispered voice test or the spoken voice test as a preliminary to conducting the audiometric hearing test.

SECTION VI. ENDOCRINE AND METABOLIC DISORDERS

★2-8. Endocrine and Metabolic Disorders

The causes for rejection for

appointment, enlistment, and induction are—

a. Adrenal gland, malfunction of, of any degree.

b. *Cretinism*.

c. *Diabetes insipidus*.

d. *Diabetes mellitus*.

e. *Gigantism or acromegaly*.

f. *Glycosuria*, persistent, regardless of cause.

g. *Goiter*:

(1) Simple goiter with definite pressure symptoms or so large in size as to interfere with the wearing of a military uniform or military equipment.

(2) *Thyrotoxicosis*.

h. *Gout*.

i. *Hyperinsulinism*, confirmed, symptomatic.

j. *Hyperparathyroidism* and *hypoparathyroidism*.

k. *Hypopituitarism*, severe.

l. *Myxedema*, spontaneous or postoperative (with clinical manifestations and not based solely on low basal metabolic rate).

m. *Nutritional deficiency diseases* (including sprue, beriberi, pellagra, and scurvy) which are more than mild and not readily remediable or in which permanent pathological changes have been established.

n. *Other endocrine or metabolic disorders* which obviously preclude satisfactory performance of duty or which require frequent and prolonged treatment.

SECTION VII. EXTREMITIES

2-9. Upper Extremities

(See para. 2-11.)

The causes for rejection for appointment, enlistment, and induction are—

a. *Limitation of motion*. An individual will be considered unacceptable if the joint ranges of motion are less than the measurements listed below (app. IV).

(1) *Shoulder*:

(a) Forward elevation to 90°.

(b) Abduction to 90°.

(2) *Elbow*:

(a) Flexion to 100°.

(b) Extension to 15°.

(3) *Wrist*: A total range of 15° (extension plus flexion).

(4) *Hand*: Pronation to the first quarter of the normal arc.

Supination to the first

quarter of the normal arc.

(5) *Fingers*: Inability to clench fist, pick up a pin or needle, and grasp an object.

b. *Hand and fingers*:

(1) Absence (or loss) of more than $\frac{1}{3}$ of the distal phalanx of either thumb.

(2) Absence (or loss) of distal and middle phalanx of an index, middle or ring finger of either hand irrespective of the absence (or loss) of little finger.

(2.1) Absence of more than the distal phalanx of any two of the following fingers, index, middle finger or ring finger, of either hand.

(3) Absence of hand or any portion thereof ex-

cept for fingers as noted above.

(4) Hyperdactylia.

(5) Scars and deformities of the fingers and/or hand which impair circulation, are so disfiguring as to make the individual objectionable in ordinary social relationships, or which impair normal function to such a degree as to interfere with the satisfactory performance of military duty.

c. Wrist, forearm, elbow, arm, and shoulder: Healed disease or injury of wrist, elbow, or shoulder with residual weakness or symptoms of such a degree as to preclude satisfactory performance of duty.

2-10. Lower Extremities

(See para. 2-11.)

The causes for rejection for appointment, enlistment, and induction are—

a. Limitation of motion. An individual will be considered unacceptable if the joint ranges of motion are less than the measurements listed below (app. IV).

(1) *Hip.*

(a) Flexion to 90°.

(b) Extension to 10°
(beyond 0).

(2) *Knee.*

(a) Full extension.

(b) Flexion to 90°.

(3) *Ankle.*

(a) Dorsiflexion to 10°.

(b) Plantar flexion to 10°.

(4) *Toes.* Stiffness which interferes with walking, marching, running, or jumping.

b. Foot and ankle.

(1) Absence of one or more small toes of one or both feet, if function of the foot is poor or running or jumping is precluded, or absence of foot or any portion thereof except for toes as noted herein.

(2) Absence (or loss) of great toe(s) or loss of dorsal flexion thereof if function of the foot is impaired.

(3) Claw toes precluding the wearing of combat service boots.

(4) Clubfoot.

(5) Flatfoot, pronounced cases, with decided eversion of the foot and marked bulging of the inner border, due to inward rotation of the astragalus, regardless of the presence or absence of symptoms.

(6) Flatfoot, spastic.

(7) Hallux valgus, if severe and associated with marked exostosis or bunion.

(8) Hammer toe which interferes with the wearing of combat service boots.

(9) Healed disease, injury, or deformity including hyperdactylia which precludes running, is accompanied by disabling pain, or which prohibits wearing of

combat service boots.

- (10) Ingrowing toe nails, if severe, and not remediable.
- (11) Obliteration of the transverse arch associated with permanent flexion of the small toes.
- (12) Pes cavus, with contracted plantar fascia, dorsiflexed toes, tenderness under the metatarsal heads, and callosity under the weight bearing areas.

c. Leg, knee, thigh, and hip.

- (1) Dislocated semilunar cartilage, loose or foreign bodies within the knee joint, or history of surgical correction of same if—

- (a) Within the preceding 6 months.

- (b) Six months or more have elapsed since operation without recurrence, and there is instability of the knee ligaments in lateral or anteroposterior directions in comparison with the normal knee or abnormalities noted on X-ray, there is significant atrophy or weakness of the thigh musculature in comparison with the normal side, there is not acceptable active motion in flexion and extension; or there are other symptoms of internal derangement.

- (2) Authentic history or

physical findings of an unstable or internally deranged joint causing disabling pain or seriously limiting function. Individuals with verified episodes of buckling or locking of the knee who have not undergone satisfactory surgical correction or if, subsequent to surgery, there is evidence of more than mild instability of the knee ligaments in lateral and anteroposterior directions in comparison with the normal knee, weakness or atrophy of the thigh musculature in comparison with the normal side, or if the individual requires medical treatment of sufficient frequency to interfere with the performance of military duty.

d. General

- (1) Deformities of one or both lower extremities which have interfered with function to such a degree as to prevent the individual from following a *physically active* vocation in civilian life or which would interfere with the satisfactory completion of prescribed training and performance of military duty.

- (2) Diseases or deformities of the hip, knee, or ankle joint which interfere with walking, run-

ning, or weight bearing.

- (3) Pain in the lower back or leg which is intractable and disabling to the degree of interfering with walking, running, and weight bearing.
- (4) Shortening of a lower extremity resulting in any limp of noticeable degree.

2-11. Miscellaneous

(See also para 2-9 and 2-10.)

The causes for rejection for appointment, enlistment, and induction are—

a. Arthritis.

- (1) Active or subacute arthritis, including Marie-Strumpell type.
- (2) Chronic osteoarthritis or traumatic arthritis of isolated joints of more than minimal degree, which has interfered with the following of a physically active vocation in civilian life or which precludes the satisfactory performance of military duty.
- (3) Documented clinical history of rheumatoid arthritis.
- (4) Traumatic arthritis of a major joint of more than minimal degree.

b. Disease of any bone or joint, healed, with such resulting deformity or rigidity that function is impaired to such a degree that it will interfere with military service.

c. Dislocation, old unreduced; substantiated history of recurrent dislocations of major joints; instability of a major joint, symptomatic and more than mild; or if, subsequent to surgery, there is evidence of more than mild instability in comparison with the normal joint, weakness or atrophy in comparison with the normal side, or if the individual requires medical treatment of sufficient frequency to interfere with the performance of military duty.

d. Fractures.

- (1) Malunited fractures that interfere significantly with function.
- (2) Ununited fractures.
- (3) Any old or recent fracture in which a plate, pin, or screws were used for fixation and left in place and which may be subject to easy trauma, i.e., as a plate tibia, etc.

e. Injury of a bone or joint within the preceding 6 weeks, without fracture or dislocation, of more than a minor nature.

f. Muscular paralysis, contracture, or atrophy, if progressive or of sufficient degree to interfere with military service.

f.1 Myotonia congenita. Confirmed.

g. Osteomyelitis, active or recurrent, of any bone or substantiated history of osteomyelitis of any of the long bones unless successfully treated 2 or more years previously without subsequent recurrence or disqualifying sequelae as demonstrated by both clinical and X-ray evidence.

b. Osteoporosis.

i. Scars, extensive, deep, or adherent, of the skin and soft tissues or neuromas of an extremity which are painful, which interfere with muscular movements, which preclude the

wearing of military equipment, or that show a tendency to break down.

★*j. Chondromalacia*, manifested by verified history of joint effusion, interference with function, or residuals from surgery.

SECTION VIII. EYES AND VISION

2-12. Eyes

The causes for rejection for appointment, enlistment, and induction are—

a. Lids.

- (1) Blepharitis, chronic more than mild. Cases of acute blepharitis will be rejected until cured.
- (2) Blepharospasm.
- (3) Dacryocystitis, acute or chronic.
- (4) Destruction of the lids, complete or extensive, sufficient to impair protection of the eye from exposure.
- (5) Disfiguring cicatrices and adhesions of the eyelids to each other or to the eyeball.
- (6) Growth or tumor of the eyelid other than small early basal cell tumors of the eyelid, which can be cured by treatment, and small nonprogressive asymptomatic benign lesions. See also paragraphs 2-40 and 2-41.
- (7) Marked inversion or eversion of the eyelids sufficient to cause unsightly appearance or watering of eyes (entropion or ectropion).
- (8) Lagophthalmos.

(9) Ptosis interfering with vision.

(10) Trichiasis, severe.

b. Conjunctiva.

(1) Conjunctivitis, chronic, including vernal catarrh and trachoma. Individuals with acute conjunctivitis are unacceptable until the condition is cured.

(2) Pterygium:

(a) Pterygium recurring after three operative procedures.

(b) Pterygium encroaching on the cornea in excess of 3 millimeters or interfering with vision.

c. Cornea.

(1) Dystrophy, corneal, of any type including keratoconus of any degree.

(2) Keratitis, acute or chronic.

(3) Ulcer, corneal; history of recurrent ulcers or corneal abrasions (including herpetic ulcers).

(4) Vascularization or opacification of the cornea from any cause which interferes with visual function or is progressive.

d. Uveal tract. Inflammation of the uveal tract except healed

traumatic choroiditis.

e. Retina.

- (1) Angiomas, phakomatoses, retinal cysts, and other congenito-hereditary conditions that impair visual function.
- (2) Degenerations of the retina to include macular cysts, holes, and other degenerations (hereditary or acquired degenerative changes) and other conditions affecting the macula. All types of pigmentary degenerations (primary and secondary).
- (3) Detachment of the retina or history of surgery for same.
- (4) Inflammation of the retina (retinitis or other inflammatory conditions of the retina to include Coat's disease, diabetic retinopathy, Eales' disease, and retinitis proliferans).

f. Optic nerve.

- (1) Congenito - hereditary conditions of the optic nerve or any other central nervous system pathology affecting the efficient function of the optic nerve.
- (2) Optic neuritis, neuroretinitis, or secondary optic atrophy resulting therefrom or document history of attacks of retrobulbar neuritis.
- (3) Optic atrophy (primary or secondary).
- (4) Papilledema.

g. Lens.

- (1) Aphakia (unilateral or bilateral).
- (2) Dislocation, partial or complete, of a lens.
- (3) Opacities of the lens which interfere with vision or which are considered to be progressive.

h. Ocular mobility and motility.

- (1) Diplopia, documented, constant or intermittent from any cause or of any degree interfering with visual function (i.e., may suppress).
- (2) Diplopia, monocular, documented, interfering with visual function.
- (3) Nystagmus, with both eyes fixing, congenital or acquired.
- (4) Strabismus of 40 prism diopters or more, uncorrectable by lenses to less than 40 diopters.
- (5) Strabismus of any degree accompanied by documented diplopia.
- (6) Strabismus, surgery for the correction of, within the preceding 6 months.

i. Miscellaneous defects and diseases.

- (1) Abnormal conditions of the eye or visual fields due to diseases of the central nervous system.
- (2) Absence of an eye.
- (3) Asthenopia severe.
- (4) Exophthalmos, unilateral or bilateral.

- (5) Glaucoma, primary or secondary.
- (6) Hemianopsia of any type.
- (7) Loss of normal pupillary reflex reactions to light or accommodation to distance or Adies syndrome.
- (8) Loss of visual fields due to organic disease.
- (9) Night blindness associated with objective disease of the eye. Verified congenital night blindness.
- (10) Residuals of old contusions, lacerations, penetrations, etc, which impair visual function required for satisfactory performance of military duty.
- (11) Retained intra-ocular foreign body.
- (12) Tumors. See a(6) above and paragraphs 2-40 and 2-41.
- (13) Any organic disease of the eye or adnexa not specified above which threatens continuity of vision or impairment of visual function.

2-13. Vision

The causes for medical rejection

for appointment, enlistment, and induction are listed below. The special administrative criteria for officer assignment to Armor, Artillery, Infantry, Corps of Engineers, Signal Corps, and Military Police Corps are listed in paragraph 7-15.

a. Distant visual acuity. Distant visual acuity of any degree which does not correct to at least one of the following:

- (1) 20/40 in one eye and 20/70 in the other eye.
- (2) 20/30 in one eye and 20/100 in the other eye.
- (3) 20/20 in one eye and 20/400 in the other eye.

b. Near visual acuity. Near visual acuity of any degree which does not correct to at least J-6 in the better eye.

c. Refractive error. Any degree of refractive error in spherical equivalent of over -8.00 or $+8.00$; or if ordinary spectacles cause discomfort by reason of ghost images, prismatic displacement, etc.; or if an ophthalmological consultation reveals a condition which is disqualifying.

d. Contact lens. Complicated cases requiring contact lens for adequate correction of vision as keratoconus, corneal scars, and irregular astigmatism.

SECTION IX. GENITOURINARY SYSTEM

2-14. Genitalia

(See also para 2-40 and 2-41.)

The causes for rejection for appointment, enlistment, and induction are—

a. Bartholinitis, Bartholin's cyst.

b. Cervicitis, acute or chronic manifested by leukorrhea.

c. Dysmenorrhea, incapacitating to a degree which necessi-

tates recurrent absences of more than a few hours from routine activities.

d. Endometriosis, or confirmed history thereof.

e. Hermaphroditism.

f. Menopausal syndrome, either physiologic or artificial if manifested by more than mild constitutional or mental symptoms, or artificial menopause if less than 13 months have elapsed since cessation of menses. In all cases of artificial menopause, the clinical diagnosis will be reported; if accomplished by surgery, the pathologic report will be obtained and recorded.

g. Menstrual cycle, irregularities of, including menorrhagia, if excessive; metrorrhagia; polymenorrhea; amenorrhea, except as noted in *f* above.

h. New growths of the internal or external genitalia except single uterine fibroid, subserous, asymptomatic, less than 3 centimeters in diameter, with no general enlargement of the uterus. See also paragraphs 2-40 and 2-41.

and considered to be of clinical
i. Oophoritis, acute or chronic.

j. Ovarian cysts, persistent and considered to be of clinical significance.

k. Pregnancy.

l. Salpingitis, acute or chronic.

m. Testicle(s). (See also para 2-40 and 2-41.)

(1) Absence or nondescent of both testicles.

(2) Undiagnosed enlargement or mass of testicle or epididymis.

(3) Undescended testicle.

n. Urethritis, acute or chronic, other than gonorrheal urethritis without complications.

o. Uterus.

(1) Cervical polyps, cervical ulcer, or marked erosion.

(2) Endocervicitis, more than mild.

(3) Generalized enlargement of the uterus due to any cause.

(4) Malposition of the uterus if more than mildly symptomatic.

p. Vagina.

(1) Congenital abnormalities or severe lacerations of the vagina.

(2) Vaginitis, acute or chronic, manifested by leukorrhea.

q. Varicocele or hydrocele, if large or painful.

r. Vulva.

(1) Leukoplakia.

(2) Vulvitis, acute or chronic.

s. Major abnormalities and defects of the genitalia such as a change of sex, a history thereof, or complications (adhesions, disfiguring scars, etc.) residual to surgical correction of these conditions.

2-15. Urinary System

(See para 2-8, 2-40, and 2-41). The causes for rejection for appointment, enlistment, and induction are—

a. Albuminuria if persistent or recurrent including so-called orthostatic or functional albuminuria.

b. Cystitis, chronic. Individuals with acute cystitis are unac-

ceptable until the condition is cured.

c. Enuresis determine to be a symptom of an organic defect not amenable to treatment. (See also para 2-34c.)

d. Epispadias or hypospadias when accompanied by evidence of infection of the urinary tract or if clothing is soiled when voiding.

e. Hematuria, cylindruria, or other findings indicative of renal tract disease.

f. Incontinence of urine.

g. Kidney.

(1) Absence of one kidney, regardless of cause.

(2) Acute or chronic infections of the kidney.

(3) Cystic or polycystic kidney, confirmed history of.

(4) Hydronephrosis or pyonephrosis.

(5) Nephritis, acute or chronic.

(6) Pyelitis, pyelonephritis.

h. Penis, amputation of, if the resulting stump is insufficient to

permit micturition in a normal manner.

i. Peyronie's disease.

j. Prostate gland, hyperthrophy of, with urinary retention.

k. Renal calculus.

(1) Substantiated history of bilateral renal calculus at any time.

(2) Verified history of renal calculus at any time with evidence of stone formation within the preceding 12 months, current symptoms or positive X-ray for calculus.

l. Skeneitis.

m. Urethra.

(1) Stricture of the urethra.

(2) Urethritis, acute or chronic, other than gonorrheal urethritis without complications.

n. Urinary fistula.

o. Other diseases and defects of the urinary system which obviously preclude satisfactory performance of duty or which require frequent and prolonged treatment.

SECTION X. HEAD AND NECK

2-16. Head

The causes for rejection for appointment, enlistment, and induction are—

a. Abnormalities which are apparently temporary in character resulting from recent injuries until a period of 3 months has elapsed. These include severe contusions and other wounds of the scalp and cerebral concussion. See paragraph 2-31.

b. Deformities of the skull in the nature of depressions, ex-

ostoses, etc., of a degree which would prevent the individual from wearing a gas mask or military headgear.

c. Deformities of the skull of any degree associated with evidence of disease of the brain, spinal cord, or peripheral nerves.

d. Depressed fractures near central sulcus with or without convulsive seizures.

e. Loss or congenital absence of the bony substance of the skull not successfully corrected

by reconstructive material:

(1) All cases involving absence of the bony substance of the skull which have been corrected but in which the defect is in excess of 1 square inch or the size of a 25 cent piece, will be referred to The Surgeon General together with a report of consultation:

(2) The report of consultation will include an evaluation of any evidence of alteration of brain function in any of its several spheres, i.e., intelligence, judgment, perception, behavior, motor control and sensory function as well as any evidence of active bone disease or other related complications. Current X-rays and other pertinent laboratory data will accompany such a report of consultation.

f. *Unsightly deformities*, such as large birthmarks, large hairy moles, extensive scars, and mutilations due to injuries or surgical operations; ulcerations; fistulae, atrophy, or paralysis of part of the face or head.

2-17. Neck

The causes for rejection for ap-

pointment, enlistment, and induction are—

a. *Cervical ribs* if symptomatic, or so obvious that they are found on routine physical examination. (Detection based primarily on X-ray is not considered to meet this criterion.)

b. *Congenital cysts* of branchial cleft origin or those developing from the remnants of the thyroglossal duct, with or without fistulous tracts.

c. *Fistula*, chronic draining, of any type.

★d. (Deleted)

e. *Nonspastic contraction* of the muscles of the neck or cicatricial contracture of the neck to the extent that it interferes with the wearing of a uniform or military equipment or so disfiguring as to make the individual objectionable in common social relationships.

f. *Spastic contraction* of the muscles of the neck, persistent, and chronic.

g. *Tumor of thyroid or other structures of the neck*. See paragraphs 2-40 and 2-41.

SECTION XI. HEART AND VASCULAR SYSTEM

2-18. Heart

The causes for rejection for appointment, enlistment, and induction are—

a. *All organic valvular diseases of the heart*, including those improved by surgical procedures.

b. *Coronary artery disease or*

myocardial infarction, old or recent or true angina pectoris, at any time.

c. *Electrocardiographic evidence* of major arrhythmias such as—

(1) Atrial tachycardia, flutter, or fibrillation, ventricular tachycardia or fibrillation.

(2) Conduction defects

such as first degree atrio-ventricular block and right bundle branch block. (These conditions occurring as isolated findings are not unfitting when cardiac evaluation reveals no cardiac disease.)

(3) Left bundle block, 2d and 3d degree AV block.

(4) Unequivocal electrocardiographic evidence of old or recent myocardial infarction; coronary insufficiency at rest or after stress; or evidence of heart muscle disease.

d. Hypertrophy or dilatation of the heart as evidenced by clinical examination or roentgenographic examination and supported by electrocardiographic examination. Care should be taken to distinguish abnormal enlargement from increased diastolic filling as seen in the well conditioned subject with a sinus bradycardia. Cases of enlarged heart by X-ray not supported by electrocardiographic examination will be forwarded to The Surgeon General for evaluation.

e. Myocardial insufficiency (congestive circulatory failure, cardiac decompensation) obvious or covert, regardless of cause.

f. Paroxysmal tachycardia within the preceding 5 years, or at any time if recurrent or disabling or if associated with electrocardiographic evidence of accelerated A-V conduction (Wolff-Parkinson-White).

★*g. Pericarditis; endocarditis; or myocarditis*, history or finding of, except for a history of a single acute idiopathic or coxsackie pericarditis with no re-

siduals, or tuberculous pericarditis inactive for 2 years.

b. Tachycardia persistent with a resting pulse rate of 100 or more, regardless of cause.

2-19. Vascular System

The causes for rejection for appointment, enlistment, and induction are—

a. Congenital or acquired lesions of the aorta and major vessels, such as syphilitic aortitis, demonstrable atherosclerosis which interferes with circulation, congenital or acquired dilation of the aorta (especially if associated with other features of Marfan's syndrome), and pronounced dilation of the main pulmonary artery.

b. Hypertension evidenced by preponderant blood pressure readings of 150-mm or more systolic in an individual over 35 years of age or preponderant readings of 140-mm or more systolic in an individual 35 years of age or less. Preponderant diastolic pressure over 90-mm diastolic is cause for rejection at any age.

c. Marked circulatory instability as indicated by orthostatic hypotension, persistent tachycardia, severe peripheral vasomotor disturbances and sympatheticotonia.

d. Peripheral vascular disease including Raynaud's phenomena, Buerger's disease (thromboangiitis obliterans), erythromelalgia, arteriosclerotic and diabetic vascular diseases. Special tests will be employed in doubtful cases.

e. Thrombophlebitis.

(1) History of thrombophlebitis with persistent thrombus or evidence of circulatory obstruction or deep venous incompetence in the involved veins.

(2) Recurrent thrombophlebitis.

f. Varicose veins, if more than mild, or if associated with edema, skin ulceration, or residual scars from ulceration.

2-20. Miscellaneous

The causes for rejection for appointment, enlistment, and induction are—

a. Aneurysm of the heart or major vessel, congenital or acquired.

b. History and evidence of a congenital abnormality which has been treated by surgery but with residual abnormalities or complications, for example:

Patent ductus arteriosus with residual cardiac enlargement or pulmonary hypertension: resection of a coarctation of the aorta without a graft when there are other cardiac abnormalities or complications; closure of a secundum type atrial septal defect when there are residual abnormalities or complications.

c. Major congenital abnormalities and defects by the heart and vessels unless satisfactorily corrected without residuals or complications. Uncomplicated dextrocardia and other minor asymptomatic anomalies are acceptable.

d. Substantiated history of rheumatic fever or chorea within the previous 2 years, recurrent attacks of rheumatic fever or chorea at any time, or with evidence of residual cardiac damage.

SECTION XII. HEIGHT, WEIGHT, AND BODY BUILD

2-21. Height

The causes for rejection for appointment, enlistment, and induction are—

a. For appointment.

(1) *Men. Regular Army*—Height below 66 inches or over 80 inches. (See administrative criteria in para 7-13.) Other—Height below 60 inches or over 80 inches.

(2) *Women.* Height below 58 inches or over 72 inches.

b. For enlistments and induction.

(1) *Men.* Height below 60 inches or over 80 inches for Army and Air Force.

(2) *Men.* Height below 60 inches and over 78 inches for Navy and Marine Corps.

(3) *Women.* Height below 58 inches or over 72 inches.

2-22. Weight

The causes for rejection for appointment, enlistment, and induction are—

a. Weight related to height which is below the minimum

shown in table I, appendix III for men and table II, appendix III for women.

b. Weight related to age and height which is in excess of the maximum shown in table I, appendix III for men and table II, appendix III for women. See chapter 7 for special requirements pertaining to maximum weight standards applicable to women enlisting for and commissioned from Army Student Nurse and Army Student Dietician Programs.

2-23. Body Build

The causes for rejection for appointment, enlistment, and induction are—

a. Congenital malformation of bones and joints. (See para

2-9, 2-10, and 2-11.)

b. Deficient muscular development which would interfere with the completion of required training.

c. Evidences of congenital asthenia (slender bones; weak thorax; visceroptosis; severe, chronic constipation; or "drop heart" if marked in degree).

d. Obesity. Even though the individual's weight is within the maximum shown in table I or II, as appropriate, appendix III, he will be reported as medically unacceptable when the medical examiner considers that the individual's weight in relation to the bony structure and musculature, constitutes obesity of such a degree as to interfere with the satisfactory completion of prescribed training.

SECTION XIII. LUNGS AND CHEST WALL

2-24. General

The following conditions are causes for rejection for appointment, enlistment and induction until further study indicates recovery without disqualifying sequelae:

a. Abnormal elevation of the diaphragm on either side.

b. Acute abscess of the lung.

c. Acute bronchitis until the condition is cured.

d. Acute fibrinous pleurisy, associated with acute nontuberculous pulmonary infection.

e. Acute mycotic disease of the lung such as coccidioidomycosis and histoplasmosis.

f. Acute nontuberculous pneumonia.

g. Foreign body in trachea or bronchus.

h. Foreign body of the chest wall causing symptoms.

i. Lobectomy, history of, for a nontuberculous nonmalignant lesion with residual pulmonary disease. Removal of more than one lobe is cause for rejection regardless of the absence of residuals.

j. Other traumatic lesions of the chest or its contents.

★*k. Pneumothorax* of history thereof within 1 year of date of examination if due to simple trauma or surgery; within 3 years of date of examination if of spontaneous origin. Surgical correction is acceptable if no significant residual disease or

deformity remains and pulmonary function tests are within normal limits.

l. Recent fracture of ribs, sternum, clavicle, or scapula.

m. Significant abnormal findings on physical examination of the chest.

2-25. Tuberculous Lesions

The causes for rejection for appointment, enlistment, and induction are—

a. Active tuberculosis in any form or location.

★*b. Pulmonary tuberculosis, active within previous 2 years.*

★*c. Substantiated history of one or more reactivations or relapses of pulmonary tuberculosis, or other definite evidence of poor host resistance to the tubercle bacillus.*

2-26. Nontuberculous Lesions

The causes for rejection for appointment, enlistment, and induction are—

a. Acute mastitis, chronic cystic mastitis, if more than mild.

b. Bronchial asthma, except for childhood asthma with a trustworthy history of freedom from symptoms since the 12th birthday.

c. Bronchitis, chronic with evidence of pulmonary function disturbance.

d. Bronchiectasis.

e. Bronchopleural fistula.

f. Bullous or generalized pulmonary emphysema.

g. Chronic abscess of lung.

h. Chronic fibrous pleuritis of sufficient extent to interfere with pulmonary function or obscure the lung field in the roentgenogram.

i. Chronic mycotic diseases of the lung including coccidioidomycosis; residual cavitation or more than a few small sized inactive and stable residual modules demonstrated to be due to mycotic disease.

j. Empyema, residual sacculation or unhealed sinuses of chest wall following operation for empyema.

k. Extensive pulmonary fibrosis from any cause, producing dyspnea on exertion.

l. Foreign body of the lung or mediastinum causing symptoms or active inflammatory reaction.

m. Multiple cystic disease of the lung or solitary cyst which is large and incapacitating.

n. New growth of breast; history of mastectomy.

o. Osteomyelitis of rib, sternum, clavicle, scapula, or vertebra.

★*p. Pleurisy with effusion of unknown origin within the previous 2 years.*

q. Sarcoidosis. See paragraph 2-38.

r. Suppurative periostitis of rib, sternum, clavicle, scapula, or vertebra.

SECTION XIV. MOUTH, NOSE, PHARYNX, TRACHEA, ESOPHAGUS, AND LARYNX

2-27. Mouth

The causes for rejection for ap-

pointment, enlistment, and induction are—

a. Hard palate, perforation of.

b. Harelip, unless satisfactorily repaired by surgery.

c. Leukoplakia, if severe.

d. Lips, unsightly mutilations of, from wounds, burns, or disease.

e. Ranula, if extensive. For other tumors see para 2-10 and 2-41

2-28. Nose

The causes for rejection for appointment, enlistment, and induction are—

★*a. Allergic manifestations.*

(1) Chronic atrophic rhinitis.

(2) Hay fever if severe; and if not controllable by antihistamines or by desensitization, or both.

b. Choana, atresia, or stenosis of, if symptomatic.

c. Nasal septum, perforation of:

(1) Associated with interference of function, ulceration of crusting, and when the result of organic disease.

(2) If progressive.

(3) If respiration is accompanied by a whistling sound,

d. Sinusitis, acute.

e. Sinusitis, chronic, when more than mild:

(1) Evidenced by any of the following: Chronic purulent nasal discharge, large nasal polyps, hyperplastic changes of the nasal tissues, or symptoms requiring frequent medical attention.

(2) Confirmed by transillumination or X-ray examination or both.

2-29. Pharynx, Trachea, Esophagus, and Larynx

The causes for rejection for appointment, enlistment, and induction are—

a. Esophagus, organic disease of, such as ulceration, varices, achalasia; peptic esophagitis; if confirmed by appropriate X-ray or esophagoscopy examinations.

b. Laryngeal paralysis, sensory or motor, due to any cause.

c. Larynx, organic disease of, such as neoplasm, polyps, granuloma, ulceration, and chronic laryngitis.

d. Plica dysphonia venricularis.

e. Tracheostomy or tracheal fistula.

2-30. Other Defects and Diseases

The causes for rejection for appointment, enlistment, and induction are—

a. Aphonia.

b. Deformities or conditions of the mouth, throat, pharynx, larynx, esophagus, and nose which interfere with mastication and swallowing of ordinary food, with speech, or with breathing.

c. Destructive syphilitic disease of the mouth, nose, throat, larynx, or esophagus. (See para 2-42.)

d. Pharyngitis and nasopharyngitis, chronic, with positive history and objective evidence, if of such a degree as to result in excessive time lost in the military environment.

SECTION XV. NEUROLOGICAL DISORDERS

2-31. Neurological Disorders

The causes for rejection for appointment, enlistment, and induction are—

a. Degenerative disorders.

(1) Cerebellar and Friedreich's ataxia.

(2) Cerebral arteriosclerosis.

(3) Encephalomyelitis, residuals of, which preclude the satisfactory performance of military duty.

(4) Huntington's chorea.

(5) Multiple sclerosis.

(6) Muscular atrophies and dystrophies of any type.

b. Miscellaneous.

(1) Congenital malformations if associated with neurological manifestations and meningocele even if uncomplicated.

(2) Migraine when frequent and incapacitating.

(3) Paralysis or weakness, deformity, discoordination, pain, sensory disturbance, intellectual deficit, disturbances of consciousness, or personality ab-

normalities regardless of cause which is of such a nature or degree as to preclude the satisfactory performance of military duty.

(4) Tremors, spasmodic torticollis, athetosis or other abnormal movements more than mild.

c. Neurosyphilis of any form (general paresis, tabes dorsalis, meningovascular syphilis).

d. Paroxysmal convulsive disorders, disturbances of consciousness, all forms of psychomotor or temporal lobe epilepsy or history thereof except for seizures associated with toxic states or fever during childhood up to the age of 12.

e. Peripheral nerve disorder.

(1) Polyneuritis.

(2) Mononeuritis or neuralgia which is chronic or recurrent and of an intensity that is periodically incapacitating.

(3) Neurofibromatosis.

f. Spontaneous subarachnoid hemorrhage, verified history of, unless cause has been surgically corrected.

SECTION XVI. PSYCHOSES, PSYCHONEUROSES, AND PERSONALITY DISORDERS

2-32. Psychoses

The causes for rejection for appointment, enlistment, and induction are—

Psychosis or authenticated history of a psychotic illness other than those of a brief duration associated with a toxic or infectious process.

2-33. Psychoneuroses

The causes for rejection for appointment, enlistment, and induction are—

a. History of a psychoneurotic reaction which caused—

(1) Hospitalization.

(2) Prolonged care by a physician.

(3) Loss of time from normal pursuits for repeated periods even if of brief duration, or

(4) Symptoms or behavior of a repeated nature which impaired school or work efficiency.

b. History of a brief psychoneurotic reaction or nervous disturbance within the preceding 12 months which was sufficiently severe to require medical attention or absence from work or school for a brief period (maximum of 7 days).

2-34. Personality Disorders

The causes for rejection for appointment, enlistment, and induction are—

a. Character and behavior disorders, as evidenced by—

(1) Frequent encounters with law enforcement agencies, or antisocial attitudes or behavior which, while not a cause for administrative rejection, are tangible evidence of an impaired characterological capacity to adapt to the military service.

(2) Overt homosexuality

or other forms of sexual deviant practices such as exhibitionism, tranvestism, voyeurism, etc.

(3) Chronic alcoholism or alcohol addiction.

(4) Drug addiction.

b. Character and behavior disorders where it is evident by history and objective examination that the degree of immaturity, instability, personality inadequacy, and dependency will seriously interfere with adjustment in the military service as demonstrated by repeated inability to maintain reasonable adjustment in school, with employers and fellow-workers, and other society groups.

c. Other symptomatic immaturity reactions such as authenticated evidence of enuresis which is habitual or persistent, not due to an organic condition (para 2-15c) occurring beyond early adolescence (age 12 to 14) and stammering or stuttering of such a degree that the individual is normally unable to express himself clearly or to repeat commands.

★*d. Specific learning defects* secondary to organic or functional mental disorders.

SECTION XVII. SKIN AND CELLULAR TISSUES

2-35. Skin and Cellular Tissues

The causes for rejection for appointment, enlistment, and induction are—

a. Acne. Severe, when the face is markedly disfigured, or

when extensive involvement of the neck, shoulders, chest, or back would be aggravated by or interfere with the wearing of military equipment.

b. Atopic dermatitis. With active or residual lesions in characteristic areas (face and

neck, antecubital and popliteal fossae, occasionally wrists and hands), or documented history thereof.

c. Cysts.

(1) *Cysts, other than pilonidal.* Of such a size or location as to interfere with the normal wearing of military equipment.

(2) *Cysts, pilonidal.* Pilonidal cysts, if evidenced by the presence of a tumor mass or a discharging sinus.

d. Dermatitis factitia.

e. Dermatitis herpetiformis.

f. Eczema. Any type which is chronic and resistant to treatment.

f.1 Elephantiasis or chronic lymphedema.

g. Epidermolysis bullosa; pemphigus.

h. Fungus infections, systemic or superficial types: If extensive and not amenable to treatment.

i. Furunculosis. Extensive, recurrent, or chronic.

j. Hyperhidrosis of hands or feet: Chronic or severe.

k. Ichthyosis, Severe.

l. Leprosy. Any type.

m. Leukemia cutis; mycosis fungoides; Hodgkins' disease.

n. Lichen planus.

o. Lupus erythematosus (acute subacute, or chronic) or any other dermatosis aggravated by sunlight.

p. Neurofibromatosis (Von Recklinghausen's disease).

q. Nevi or vascular tumors: If extensive, unsightly, or exposed to constant irritation.

r. Psoriasis or a verified history thereof.

s. Radiodermatitis.

t. Scars which are so extensive, deep, or adherent that they may interfere with the wearing of military equipment, or that show a tendency to ulcerate.

u. Scleroderma. Diffuse type.

v. Tuberculosis. See paragraph 2-38.

w. Urticaria. Chronic.

x. Warts, plantar, which have materially interfered with the following of a useful vocation in civilian life.

y. Xanthoma. If disabling or accompanied by hypercholesterolemia or hyperlipemia.

z. Any other chronic skin disorder of a degree or nature which requires frequent outpatient treatment or hospitalization, interferes with the satisfactory performance of duty, or is so disfiguring as to make the individual objectionable in ordinary social relationships.

★*aa. Tattoos on any part of the body* which in the opinion of the examining physician are obscene or so extensive on exposed areas as to be considered unsightly, are administratively disqualified.

SECTION XVIII. SPINE, SCAPULAE, RIBS, AND SACROILIAC JOINTS

2-36. Spine and Sacroiliac Joints

(See also para 2-11.)

The causes for rejection for appointment, enlistment, and induction are—

a. Arthritis. See paragraph 2-11a.

b. Complaint of disease or injury of the spine or sacroiliac joints either with or without objective signs and symptoms which have prevented the individual from successfully following a physically active vocation in civilian life. Substantiation or documentation of the complaint without symptoms and objective signs is required.

c. Deviation or curvature of spine from normal alignment, structure, or function (scoliosis, kyphosis, or lordosis, spina bifida occulta, spondylolysis, etc.), if—

(1) Mobility and weight-bearing power is poor.

(2) More than moderate restriction of normal physical activities is required.

(3) Of such a nature as to prevent the individual from following a *physically active vocation* in civilian life.

(4) Of a degree which will interfere with the wearing of a uniform or military equipment.

(5) Symptomatic, associated with positive physical finding(s) demonstrable by X-ray.

d. Diseases of the lumbosacral or sacroiliac joints of a chronic type and obviously associated

with pain referred to the lower extremities, muscular spasm, postural deformities and limitation of motion in the lumbar region of the spine.

e. Granulomatous diseases either active or healed.

f. Healed fracture of the spine or pelvic bones with associated symptoms which have prevented the individual from following a *physically active vocation* in civilian life or which preclude the satisfactory performance of military duty.

g. Ruptured nucleus pulposus (herniation of intervertebral disk) or history of operation for this condition.

h. Spondylolysis or spondylolisthesis that is symptomatic or is likely to interfere with performance of duty or is likely to require assignment limitations.

2-37. Scapulae, Clavicles, and Ribs

(See para 2-11.)

The causes for rejection for appointment, enlistment, and induction are—

a. Fractures, until well healed, and until determined that the residuals thereof will not preclude the satisfactory performance of military duty.

b. Injury within the preceding 6 weeks, without fracture, or dislocation, of more than a minor nature.

c. Osteomyelitis of rib, sternum, clavicle, scapula, or vertebra.

d. *Prominent scapulae* interfering with function or with

the wearing of uniform or military equipment.

SECTION XIX. SYSTEMIC DISEASES AND MISCELLANEOUS CONDITIONS AND DEFECTS

2-38. Systemic Disease

The causes for rejection for appointment, enlistment, and induction are—

a. *Dermatomyositis*.

b. *Lupus erythematosus*: acute, subacute, or chronic.

c. *Progressive systemic sclerosis*.

d. *Reiter's Disease*.

e. *Sarcoidosis*.

f. *Scleroderma*, diffuse type.

g. *Tuberculosis*:

★(1) Active tuberculosis in any form or location or substantiated history of active tuberculosis within the previous 2 years.

★(2) Substantiated history of one or more reactivations or relapses of tuberculosis in any form or location or other definite evidence of poor host resistance to the tubercle bacillus.

★(3) Residual physical or mental defects from past tuberculosis that would preclude the satisfactory performance of duty.

★(4) (Deleted).

2-39. General and Miscellaneous Conditions and Defects

The causes for rejection for appointment, enlistment, and induction are—

a. *Allergic manifestations*.

(1) Allergic rhinitis (hay fever). See paragraph 2-28.

(2) Asthma. See paragraph 2-26b.

(3) Allergic dermatoses. See paragraph 2-35.

(4) Visceral, abdominal, and cerebral allergy, if severe or not responsive to treatment.

★(5) Bona fide history of moderate or severe generalized (as opposed to local) allergic reaction to insect bites or stings. Bona fide history of severe generalized reaction to common foods, e.g., milk, eggs, beef, and pork.

b. *Any acute pathological condition*, including acute communicable diseases, until recovery has occurred without sequelae.

c. *Any deformity which is markedly unsightly or which impairs general functional ability* to such an extent as to prevent satisfactory performance of military duty.

d. *Chronic metallic poisoning* especially beryllium, manganese, and mercury. Undesirable residuals from lead, arsenic, or silver poisoning make the examinee medically unacceptable.

e. *Cold injury*, residuals of, (example: frostbite, chilblain, immersion foot, or trench foot) such as deep seated ache, paresthesia, hyperhidrosis, easily traumatized skin, cyanosis, am-

putation of any digit, or ankylosis.

f. Positive tests for syphilis with negative TPI test unless there is a documented history of adequately-treated lues or any of the several conditions which are known to give a false-positive S.T.S. (vaccinia, infectious hepatitis, immunizations, atypical pneumonia, etc.) or unless there has been a reversal to a negative S.T.S. during an appropriate followup period (3 to 6 months).

g. Filariasis; trypanosomiasis; amebiasis; schistosomiasis; uncinariasis (hookworm) associated with anemia, malnutrition, etc., if more than mild, and other similar worm or animal parasitic infestations, including the carrier states thereof.

h. Heat pyrexia (heatstroke,

sunstroke, etc.): Documented evidence of predisposition (includes disorders of sweat mechanism and previous serious episode), recurrent episodes requiring medical attention, or residual injury resulting therefrom (especially cardiac, cerebral, hepatic, and renal).

i. Industrial solvent and other chemical intoxication, chronic including carbon bisulfide, trichlorethylene, carbon tetrachloride, and methyl cellosolve.

j. Mycotic infection of internal organs.

k. Myositis or fibrositis; severe, chronic.

l. Residuals of tropical fevers and various parasitic or protozoal infestations which in the opinion of the medical examiner preclude the satisfactory performance of military duty.

SECTION XX. TUMORS AND MALIGNANT DISEASES

2-40. Benign Tumors

The causes for rejection for appointment, enlistment, and induction are—

a. Any tumor of the—

(1) Auditory canal, if obstructive.

(2) Eye or orbit (see also para 2-2a(6)).

(3) Kidney, bladder, testicle, or penis.

(4) Central nervous system and its membraneous coverings unless 5 years after surgery and no otherwise disqualifying residuals of surgery or of original lesion.

b. Benign tumors of the ab-

dominal wall if sufficiently large to interfere with military duty.

c. Benign tumors of bone likely to continue to enlarge, be subjected to trauma during military service, or show malignant potential.

d. Brain tumors of the thyroid or other structures of the neck, including enlarged lymph nodes, if the enlargement is of such degree as to interfere with the wearing of a uniform or military equipment.

e. Tongue, benign tumor of, if it interferes with function.

f. Breast, thoracic contents, or chest wall, tumors, of, other than

fibromata lipomata, and inclusion or sebaceous cysts which do not interfere with military duty.

g. *For tumors of the internal or external female genitalia* see paragraph 2-14b.

2-41. Malignant Diseases and Tumors

The causes for rejection for ap-

pointment, enlistment, and induction are—

a. *Leukemia*, acute or chronic.

b. *Malignant lymphomata*.

c. *Malignant tumor of any kind*, at any time, substantiated diagnosis of, even though surgically removed, confirmed by accepted laboratory procedures, except as noted in paragraph 2-12a(6).

SECTION XXI. VENEREAL DISEASES

2-42. Venereal Diseases

In general the finding of acute, uncomplicated venereal disease which can be expected to respond to treatment is not a cause for medical rejection for military service. The causes for rejection for appointment, enlistment, and induction are—

a. *Chronic venereal disease* which has not satisfactorily responded to treatment. The finding of a positive serologic test for syphilis following the ade-

quate treatment of syphilis is not in itself considered evidence of chronic venereal disease which has not responded to treatment (para 2-39f).

b. *Complications and permanent residuals* of venereal disease if progressive, of such nature as to interfere with the satisfactory performance of duty, or if subject to aggravation by military service.

c. *Neurosyphilis*. See paragraph 2-21c.

★SECTION XXII. VOCATIONAL WAIVERS

2-43. Vocational Waivers

When an individual who fails to meet the medical standards listed in this chapter has demonstrated in the pursuit of his civilian occupation, profession, or avocation that he is likely to be able satisfactorily to perform the duties of a member of the Armed Forces, the medical examiner may recommend to the Surgeon General of the appropriate service that such an in-

dividual be accepted on waivers of medical fitness standards. Such cases shall be considered by the Surgeon General before a final decision is made.

★7-12. Dental—Induction and Appointment or Enlistment in U.S. Army

(See para 2-5.)

a. Individuals with orthodontic appliances attached are ad-

ministratively unacceptable for the following as long as active treatment is required:

(1) Appointment as a commissioned or warrant officer in any component (except for physicians, dentists and other specialists liable for military service under the Military Selective Service Act of 1967 who will be evaluated under standards prescribed for those procurement programs).

(2) Enlistment or induction of personnel in any component of the U.S. Army.

e. Individuals with retainer orthodontic appliances who are not required to undergo active treatment are administratively acceptable for appointment, enlistment or induction.

★APPENDIX II

TABLES OF ACCEPTABLE AUDIOMETRIC HEARING LEVEL

Hearing of all applicants for appointment, enlistment, or induction will be tested by audiometers calibrated to either American Standards Association (ASA), or International Standards Organization (ISO) Standards. All audiometric tracings or audiometric reading recorded on reports of medical examination or other medical records will be clearly identified "Results ASA-1951" or "Results ISO."

Table I. Acceptable Audiometric Hearing Level for Appointment, Enlistment and Induction

American Standards Association (ASA)		International Standards Organization (ISO)	
Cycles per second (hz)	Both ears	Cycles per second (hz)	Both ears
500	Average of the 6 readings (3 per ear) in the three speech frequencies not greater than twenty (20) decibels with no level greater than twenty-five (25) decibels. 50 (each ear)	500	Average of the 6 readings (3 per ear) in the speech frequencies not greater than thirty (30) decibels with no level greater than thirty-five (35). 55 (each ear)
1000		1000	
2000		2000	
4000		4000	

OR

If the average of the three speech frequencies is greater than 20 decibels (ASA) or 30 decibels ISO reevaluate the better ear only in accordance with the following table of acceptability.

	ASA	ISO
500 (hz)	15 decibels	30 decibels
1000 (hz)	15 decibels	25 decibels
2000 (hz)	15 decibels	25 decibels
4000 (hz)	30 decibels	35 decibels
The poorer ear may be totally deaf.		

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Table IV. Conversion Table. (To convert Individual Audiograms from the American Standards Association (ASA) to International Standards Organization (ISO))

AT	ADD
250 cps	15 db
500 cps	15 db
1000 cps	10 db
2000 cps	10 db
3000 cps	10 db
4000 cps	5 db
6000 cps	10 db
8000 cps	10 db

Identify the results of each audiogram as "ASA" or "ISO."

APPENDIX III

TABLES OF WEIGHT

Table I. Table of Militarily Acceptable Weight (in Pounds) as Related to Age and Height for
Males—Initial Procurement

Height (inches)	Minimum (regardless of age)	Maximum					
		16-20 years	21-24 years	25-30 years	31-35 years	36-40 years	41 years and over
60	100	163	173	173	173	168	164
61	102	171	176	175	175	171	166
62	103	174	178	178	177	173	169
63	104	178	182	181	180	176	171
64	105	183	184	185	185	180	175
65	106	187	190	191	190	185	180
66	107	191	196	197	196	190	185
67	111	196	201	202	201	195	190

68	115	202	207	208	207	201	195
69	119	208	213	214	212	206	200
70	123	214	219	219	218	211	205
71	127	219	224	225	223	216	210
72	131	225	231	232	230	224	216
73	135	231	239	238	237	230	223
74	139	237	246	246	243	236	229
75	143	243	253	253	251	243	235
76	147	248	260	260	257	250	241
77	151	254	267	267	264	256	248
78	153	260	275	273	271	263	254
★*79	159	266	281	279	277	269	260
★*80	166	273	288	286	284	276	267

★*Applies only to personnel enlisted, inducted or appointed in Army and enlisted or inducted into Air Force.
Does not apply to Navy or Marine Corps enlistees or inductees.





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